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# COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

January, 1994

Volume 91, Number 1

University of Maryland  
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LEE A. BRICKER, MD  
"Some Thoughts  
from the  
New Doc in Town"

Cartoon by Bernice Barnes, Pueblo, Colorado

Special Book Insert

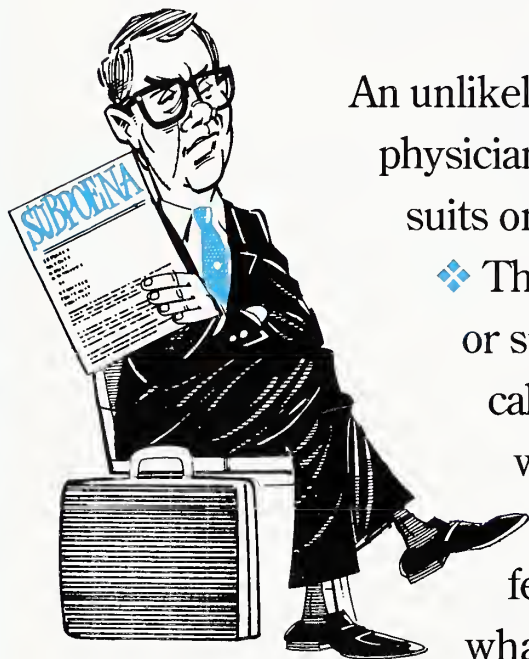
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is Issue:

Book Insert..."Some Thoughts from the New Doc in Town" .....by *Lee Bricker, MD*  
Thoughts on the National Scene ..... *Wm. Carl Bailey, MD, President*  
Alternative Health Providers and the Legislature ..... *Frederick A. Lewis, Jr., MD*  
Women's Issues on the Front Burner ..... *Louise McDonald, MD and Ingrid Justin, MD*



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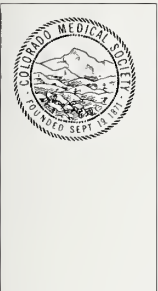
January, 1994

Volume 91, Number 1



## Cover Story

Dr. Lee Bricker of Pueblo makes some predictions for Colorado based on his experience in Florida. See the book insert in this issue.



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## Getting The Most Out of Your Computer?

In the effort to implement their new computer systems, many practices work so hard for what seems like so long getting just the basics to function properly, they neglect some secondary features that can yield some truly significant benefits.

Usually, the main function of a new medical system is to help with accounts receivable management (i.e. getting the bills out). And even after that becomes fairly routine, other billing-related functions of the new system (e.g. electronic billing) can distract users from pursuing secondary features they once looked forward to. It is not unusual for software vendors to touch base with new clients after several months only to be surprised that some of their most productive programs are not being used.

Staff turnover, especially at the management level, can exacerbate this unintentional neglect. New employees have their priorities and, again, they tend by necessity to focus on the basics; billing and collection. They may not even be aware of features their predecessors had high hopes for.

So if your system is running relatively smoothly now, you may want to take some time to look at some ancillary features that could really help you get more of your money's worth out of your system:

- 1. Appointment Scheduling.** This is without a doubt the single most overlooked feature in a medical practice system. Many have to have a scheduler when they buy a system, and yet, less than 50% ever take the time to implement it. That's really unfortunate, because a good scheduling program can

automatically prepare superbills for each day's visits in advance, track missed appointments and no-shows so patients don't "fall through the cracks", instantly locate next available time slots that meet specified criteria, quickly help with patients who call in and have forgotten when their next appointment is; actually help you manage your time and resources quite a bit more effectively than without it. Now, to be fair, many schedulers are so awkward to use that, in the end, the good old black appointment book is simply more practical. Visit the office of a practice already using the scheduler your system requires before you commit to it, to see just how feasible it could be in your office. And work closely with your vendor. Your scheduler will probably have to be an integrated software module, which means it will have to be provided by the same vendor your existing accounts receivable software comes from.

- 2. Follow-Up Procedures.** As you know, sending out insurance claims and patient statements is only half the battle. You still have to collect your money. There are features in most systems today that can be a great deal of help in this area, some of them quite beneficial. Most systems will produce a variety of reports that will let you know exactly who owes what and how overdue they are, and the best systems can even generate automatic follow-up letters, even faxes, to insurance companies or patients. A good system can also assist in making sure patients you need to recall in a specific time frame are

not forgotten.

- 3. Custom Reporting.** As with a scheduler, the practicality of this feature simply depends on how easy it is to use ("If it's not easy to use, it's easy not to use it"). But if your system can readily provide you with custom reports on demand, there are some real benefits to be derived from that capability. This also depends on the office management's creativity in coming up with ideas for turning raw data into useful information. Again, your vendor can probably help you here. After all, they work with practices using your software every day. But if they don't have any helpful ideas, ask them to put you in touch with some fellow users who do ("Who do you know who uses the report generator a lot?").

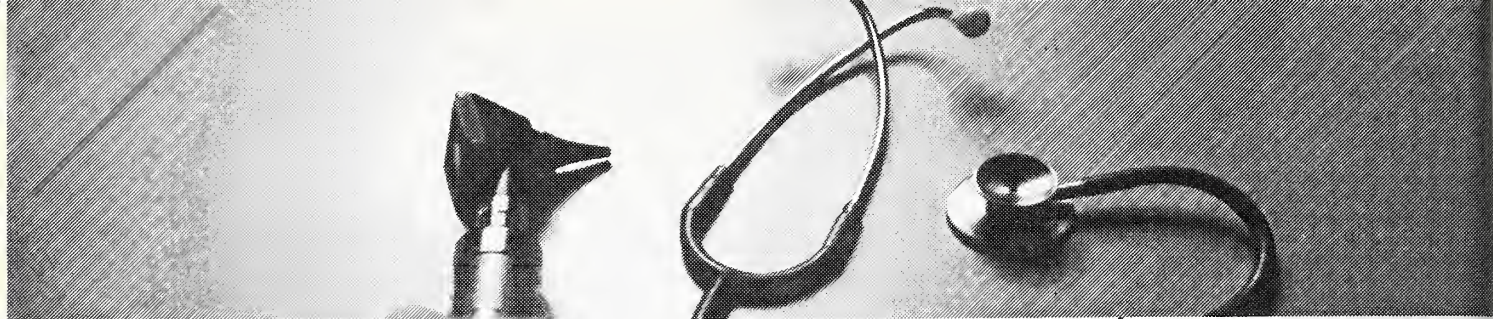
- 4. Other Software Applications.**

Chances are your system can accommodate more software than just your primary application. You may want to investigate some spreadsheets, word processors or inexpensive accounting programs (e.g. *Quicken*), that will either run directly on your current system, or can be easily connected to it.

Today, even a Macintosh can be connected to multi-user systems and PC networks. A word of warning, however: If you are going to involve more than one vendor, make sure they are capable of working closely together. Otherwise you could end up with vendor finger-pointing exercises that can really strangle office productivity.

You spent a great deal of time and money getting your system up and running. Now make sure you're getting your money's worth.





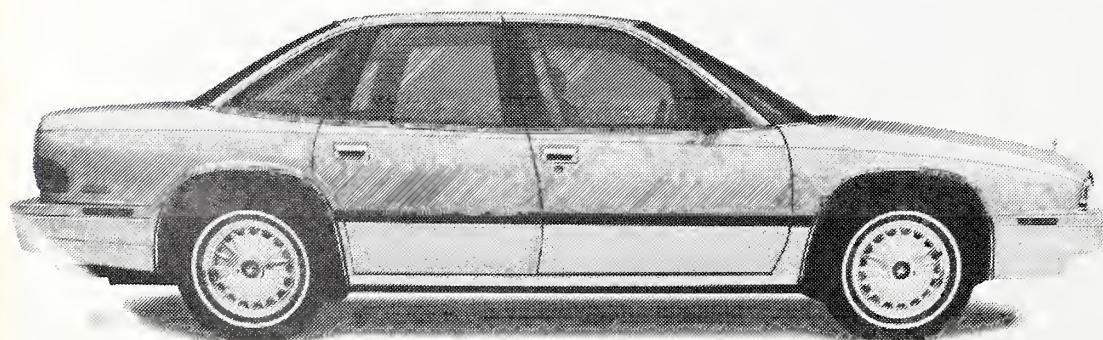
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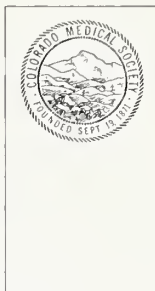
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Wm. Carl Bailey, MD  
President, 1993-1994

As this is written, the '93 Interim Meeting of the American Medical Association (AMA) House of Delegates has just concluded. Each time I witness a meeting of the House, I am awed by its complexity, by the fact that it works, and that it is probably the most democratic medical organization ever. It comes as a refreshing surprise to realize that any delegate or delegation can be heard on almost any matter germane to the business of the house. One is forced to confront the realization that if, at times, the AMA is not all that we wish it were, or if it takes positions with which we disagree, or may even feel embarrassed by, it is probably our own collective fault for not sending the appropriate message through our delegates. By the way, the next time you hear a physician angrily denounce something he or she doesn't like and concludes with a demand to know "what organized medicine is doing about it", ask that person if they are a member of CMS or AMA. I continue to be struck by the degree many of our fellow physicians who are not members continue to "freeload" on the extraordinarily hard work, not to mention the financial resources expended by the federation in behalf of all physicians.

A few things surfaced at the recent AMA meeting upon which I would like to briefly comment, speaking from a personal perspective.

First, the issue of employer mandate. This has been a staple of the Clinton Health system reform package, and was endorsed by AMA leadership. It therefore came as

surprise to many of the AMA staff and to the press when the House of Delegates took a position favoring a pluralistic approach. I think the mood of the Delegates was not a repudiation of AMA position on employer mandates, but rather a recognition that life circumstances and sources of income vary enormously, especially in a rural state. Many of us in Colorado have long felt that employer mandates as a sole method of payment are not a good idea. In fact, the employer mandate concept was deliberately omitted from the CMS policy statement on reform. The idea has additionally been opposed by small employers fearing financial ruin and who make up a large percentage of the employers of our state. In truth, some physicians, who are, in economic terms, small businessmen, would find the employer mandate an onerous burden, even though many of us have provided insurance for our office staffs in the past. Most importantly, I feel, is that if reform is to be effective, it will require that the patient assume responsibility for his own utilization of health care resources. This is best achieved when the patient not only selects his doctor and his health care plan, but also takes responsibility for paying for it directly and actually owns the insurance policy himself. This permits the consumer to be the judge of how satisfactory his care has been, and promotes constructive competition among providers.

Entitlement plans, whether funded by the government or an employer, stimulate over-utilization and are often associated with poorer

*"... if nurses want to practice medicine they should face the incredible competition to go to medical school, do a three to five year post-doctoral residency, and then come out with a debt-load of \$60,000 to \$80,000."*



## PRESIDENT'S LETTER

*(Continued)*

patient compliance and higher cost.

A second item was a proposal of the AMA to fund a sweeping survey of its own organization, mission, and relationships to State and County medical societies, as well as the specialties and other professional organizations. It is intended to review all AMA activities in the light of the revolutionary political, societal, and scientific changes which we are experiencing. There is an awareness that AMA has some problems. For example, the "graying" of the organization, the fact that only about 40% of eligible physicians belong, the fact that increasingly it is an organization composed primarily of practitioners in the traditional mode of solo and small group fee-for-service practice. There is a perceived distancing of an entrenched bureaucracy from its grass roots membership. In some cases this is a case of a think-tank with great research and planning capability simply getting ahead of the grass roots on the knowledge/power curve. Sometimes, however, some ballast needs to be provided by grass roots input, and perhaps a better way may be found to improve communication and the final product. The project carries a price tag of \$2 million and was referred for further study. I personally think it is essential that this study be carried out. It is increasingly clear that the AMA is our best and most effective voice. No single specialty group or other organization matches it in

clout. It provides us with data, information, and policy development which are critical to the future of all of our profession and the health care of the nation. We need to improve it and remedy its imperfections quickly.

A third item relates to scope of practice. As I indicated last month, there is legislation coming up in the next session of the Colorado Legislature which bears directly on who will be acknowledged as primary care providers. An urgent issue is the regulation of Naturopaths. I urge each of you to acquaint yourselves fully with the issues at stake and impart your personal opinion to your senator and representative.

A related issue which was discussed at the AMA HOD was the drive by advanced practice nurses to be granted prescription and independent practice privileges. These have already been granted in some 26 states. The nurses claim that they can provide equal or better primary care than physicians in about 80% of cases. The Clinton Administration has recently endorsed this concept fully, and is expected to lobby for it. Nurses say that physicians oppose it primarily because of feared economic loss. Physicians say that nurses themselves want it for economic gain, and that if nurses want to practice medicine they should face the incredible competition to go to medical school, do a three to five year post-doctoral residency, and then come out with a debt-load of \$60,000 to 80,000. If we are having trouble recruiting the extraordinarily bright students now applying to

medical school to go into primary care, one can only speculate what impact this may have on the future of primary care. At present, nurses are frequently employed in this role in underserved areas, but there would appear to be no more assurance that large numbers of nurses certified in this way will have any greater incentive to practice in underserved areas than do physicians now. The nurses I have talked to always emphasize that they really are only seeking "collaborative" practice, but they make it very clear that this does not mean with oversight or supervision by physicians.

We wish the nurses well and understand, in addition to the traditional role of nursing, the many expanded areas of health care in which nursing provides very valuable and essential services. But I suspect many a physician who has had a long standing and comfortable relationship working side by side with a trusted nurse whose skills and competence he is exquisitely attuned to, may still be very uncomfortable with the concept of independent nurse practice. Our profession has fought for decades for constant improvement in the standards of medical education and the delivery of care. Perhaps the notion of nurses practicing medicine without the supervision or oversight of a physician is an idea whose time has come, and is politically correct. But I hope many of us may be forgiven for feeling that by accepting this we have in fact sold out — or been sold out. The Devil is in the unintended consequences.



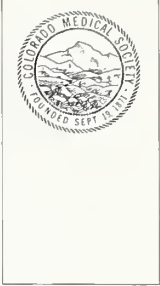
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*And... see page 17 for more information about COMPAC.*

## EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney  
Executive Director  
Colorado Medical Society

As I write this, I am somewhere over Louisiana. Yes, somewhere up in the clouds. Well I can tell you that I am not alone. I have just reread the proposed rules promulgated by the Division of Workers' Compensation (DOWC). I like them even less at 35,000 feet. The title is "Rules Governing the Enforcement of the Medical Treatment Guidelines under the Workers' Compensation Act". My gosh, sounds like a Clint Eastwood movie. I submit, however, the rules are not entertaining.

Several years ago, the Medical Society made a conscious decision to work closely with the DOWC. Since the Division was going to be creating practice guidelines, it seemed logical that Colorado physicians should be intimately involved in the establishment of such practice guidelines. We were assured that these guidelines would not be used to deny reimbursement, but only used to improve the quality of care. Made good sense. A DOWC task force created guidelines for the treatment of low back pain. These guidelines were reviewed by CMS.

Recently, the DOWC has drawn criticism from the legislature for not being efficient in the implementation of the rules related to Senate Bill 218 (enacted a couple of years ago). Complaints have been made with respect to insurers not utilizing these low back pain guidelines. Fine. One would then expect that the DOWC would establish regulations regarding the use of medical treatment guidelines by insurers. As I read the proposed rules, I find that it is the physician who are again being penalized, not the insurers.

Following are some of the proposed rules and my related comments:

*"Medical treatment guidelines may be reviewed by the Division in consultation with the medical director and the Medical Care Accreditation Commission (MCAC). Consideration shall be given to the effect of the guidelines on patient care and cost containment."*

I believe that the medical treatment guidelines MUST be reviewed annually. My interpretation of the last sentence in the above paragraph is that even if a given set of medical treatment guidelines are considered the "best", but to follow them would increase the cost of medical care, these guidelines will not be implemented. We all should have the best interest of the patient at heart. Quality, not cost containment, should be the consideration when establishing treatment guidelines.

The next couple of items state *"Payers shall routinely and regularly review claims to ensure that care is consistent with Division of Workers' Compensation medical treatment guidelines", and "It is recognized that acceptable medical practice may require a provider to deviate from the treatment guidelines where a specific medical complication or condition warrants such deviation."*

*The following procedure shall apply where a payer disputes the treatment plan which deviates from the treatment guidelines.*

- a) *The payer shall request medical justification from the provider whose treatment is being questioned to explain why the ques-*

*"The Division has no business even mentioning life-threatening circumstances."*



tioned treatment is outside or beyond the medical treatment guidelines. The payer must request this justification in writing, and the provider shall have 14 days from the date of the letter to mail a written response.

- (b) If the provider fails to mail a written response within the 14 days, or if the payer disagrees with the response, the payer shall obtain a written review by a licensed medical professional with expertise and knowledge in the area which is being contested. The review shall be in writing and completed within 14 days of the date of receipt of the treating physician's response, except where the payer requests an IME, in which case a written IME review shall be completed in 30 days."

Well, I can tell you that the insurers will use this rule to inappropriately delay as well as deny your claims. At a minimum, the insurer should have to request information at least 14 days from the date of receipt of the claim. I am also very con-

cerned about the terms "**medical justification**". We all know what Medicare does in this arena. This appears to be more bureaucratic red tape. Good luck in ever getting a claim paid!

The last point from the rule is very strange. It reads, "In a rare case of emergency or life-threatening circumstances, any party may forego the above procedures and may set the matter for a forthwith hearing before the Division of Administrative Hearings."

How absurd! We all know that physicians, especially during emergency or life-threatening circumstances can't be concerned about "**setting a matter forthwith**"! The Division has no business even mentioning life-threatening circumstances.

There is another threat looming. If these rules are not adopted (and perhaps even if they are) a major Colorado insurer will probably seek legislation in 1994 to mandate the use of practice guidelines; and making it unprofessional conduct to

not follow the workers' compensation guidelines. So, where does this leave the physicians of Colorado? It appears that there will be mandatory use of treatment guidelines. Personally, I believe that it is much better to have these guidelines in the rules and regulations, not in statute.

The proposed rules remove all reference to the fact that the low back pain guidelines can't be used for "medico-legal reasons". I am concerned about the physicians' liability when the guidelines are/are not followed. Will these guidelines be used in malpractice suits?

The public hearing for these proposed rules is scheduled for **January 6, 1994 from 9:00 AM to 12:00 PM, Room 0109, which is in the basement of the Capitol.** Considering the far-reaching implications of these rules, I suggest that you attend the hearing and let your voice be heard.

As I descend into Denver, it's wonderful to see the Rocky Mountains after a week in New Orleans. I have my head out of the clouds, perhaps other people should do the same.

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- Cutting Overhead/Operations Expenses ?
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## Medicine's Most Recent Challenge—AHPs

The CMS urgently needs to revisit its position on allied health professionals (AHPs). I am not going to attempt to offer a solution. My focus will be on the problem, and the fact that the traditional views of medicine are being challenged on all sides. There are new realities in 1994 that require us to reevaluate our position.

This is not an academic exercise. A number of bills will emerge in the 1994 legislative session that will force the CMS into taking a legislative position. I hope that the result will be a well thought-out and defensible position which will be in the best interests of the citizens of Colorado.

In the past, organized medicine has tended to respond in a somewhat reflex fashion, stating that only physicians can provide quality medical care. Physicians have made a good living doing this and, for a long time, everyone was reasonably content with the situation. However, over the past 30 years (since the advent of Medicare and Medicaid, double digit inflation, third party payment, and tremendous technological advances) the cost of medical care has increased to the point that it is 1/7 of our national economy. It is now the focus of widespread political and social concern.

As a result, people are asking whether medical care could reasonably be provided by professionals other than physicians. At the same time there has been a tremendous increase in the number of "non-physician health care practitioners" (AHPs). At the risk of missing

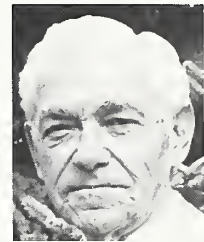
some, these include pharmacists, nurses, nurse anesthetists, nurse midwives, nurse practitioners, paramedics, physician assistants, child health associates, optometrists, chiropractors, physical therapists, psychologists, social workers, lay midwives, naturopaths, homeopaths, massage therapists, occupational therapists, biofeedback technicians, rolfers, etc.

It has become fairly obvious to most observers that various political (and insurance) groups have begun to push very hard to increase the amount of medical care rendered by these AHPs. They believe that this care can and is being furnished at less cost with absolutely no sacrifice in quality.

It is appropriate to look at these trends within the same framework we use to look at traditional medical care: cost, access, and quality.

### COST:

- Any increase in the number of providers will, inevitably, increase costs.
- There is a natural legislative progression taken by each allied health group. It goes as follows (along with the AHP rationale):
  - Certification. - (To protect the public.)
  - Licensure. - (To exclude untrained "healers".)
  - Mandatory reimbursement by 3rd party payers. - (Cheaper.)
  - Mandatory coverage by Medicaid, W.C., PIP. - (Save money.)
  - Equal pay for equal work -



Frederick A. Lewis, Jr., MD  
Chairman  
CMS Council on Legislation





### *AHPs—Allied Health Professionals*

(Equality - Nondiscrimination.)  
End result - Increase in overall cost of health care.

The plea for equality and nondiscrimination may well be compounded by accusations of "sexism" since many AHPs are traditionally female and medicine is (probably) still male dominated.

### ACCESS:

- Increases in the number of providers **should** increase access. Medicine will ask "access to what?"
- Rural areas are a big question mark. Available data seem to indicate that most AHPs tend to congregate in the same areas as physicians, i.e., urban areas.

### QUALITY:

- There is a real argument among the various health care disciplines around quality. Physicians are genuinely convinced that the highest quality health care is practiced by physicians. This is not a result of a "turf battle". Almost all physicians refer their friends and family to physicians. One suspects that AHPs and their families also obtain their medical care from physicians.
- Most thoughtful physicians would probably agree that there are areas in which adequate care can be rendered by non-physician health care practitioners (AHPs) under "ordinary, routine" circumstances. The same physicians would argue vehemently that, in medicine, things

do go wrong and, when this happens, no one but a physician will suffice. Routine well-baby checkups, uncomplicated vaginal deliveries, counseling of psychologically healthy individuals, and routine eye refraction come to mind as procedures which are probably done well, under routine circumstances, by AHPs. There are certainly many other similar areas.

The problems arise, at least for physicians, when the discussion turns to the concept of assigning solo, personal, individual responsibility to AHPs and allowing them to function in an unsupervised fashion. What happens when things "go bad?" Do they know enough to recognize when they are in over their heads?

- There is general agreement that these differences in opinion will not be settled definitely until we have adequate and sophisticated outcome studies, which simply do not exist at the present time. There are some studies which seem to suggest that the highest quality health care is delivered by physicians working in close collaboration with, or supervision of, various AHPs.

The many disciplines who call themselves allied health care practitioners have been listed in order to highlight the complexity of the problem and to suggest that there is no one simple legislative solution which can logically be applied in an equitable fashion to all of these groups.

In the past, our position has been



to say that "no one can do this but us". This position is no longer politically tenable. However, the alternative position is very complicated and has to be articulated very carefully and in great detail. We will have to establish a different position for each of these groups. This will require a tremendous amount of work which, we hope, will result in thoughtful recommendations to the Legislature.

In regard to each group, the CMS should make decisions on:

- Whether CMS can (or should) support independent practice.
- If, instead, we recommend collaboration with a physician - how much, under what circumstances, and how should it be monitored?
- Do we support prescribing privileges? - If so, with what formulary, what classes of medications, what degree of supervision, etc.?
- Do we support separate billing and separate reimbursement?
- What should the scope of practice be for each group? I anticipate that their perception of what they should be allowed to do will vary considerably from ours.
- What kind of educational background and experience should we recommend?
- How active should CMS be in fighting for public health and safety? (i.e., witness the spread of amoebic dysentery by colonic irrigation in the 1970s.)
- Should the discipline be licensed, registered, or certified? What Board should monitor its activities?
- Should we make an effort to separate the scientific disciplines

(medicine, nursing, pharmacy, etc.) from the alternate health care practitioners (chiropractors, naturopaths, rolfers, etc.)

I repeat: Do not be misled into thinking that this article is an intellectual exercise. We will be confronted in the 1994 state legislative session by bills licensing naturopaths, expanding scope of practice for advance nurse practitioners, and extending prescribing privileges to both naturopaths and nurse practitioners. In California, psychologists have begun an organized, well financed campaign for prescription privileges. In 1995, the practice acts for medicine, nursing, chiropractic, and pharmacy will come up for renewal. The Medical Practice Act contains scope of practice provisions for physician assistants and child health associates. We can anticipate that most of these groups will ask for expansion of their scope of practice.

This article has been concerned with the stance CMS should take in regard to AHPs. Let me conclude by reminding all of you that there is nothing to guarantee that the Colorado Legislature will accept our recommendations, even if they are well thought through. Our track record in this has not been all that great. We obviously cannot and should not structure our position around the potential adverse financial impact on the practice of medicine. I do not really believe this is the biggest concern of most physicians. However, you can be certain that in the legislature this is the "brush" with which we will be painted by our "allies".

## *Not just an intellectual exercise*





## ompetition and the changing role of medical societies

"My prediction for the future is that more and more physicians will be participants in a provider organization which will offer prepaid (perhaps capitation) discount fee schedules and that competition among these organizations will increase significantly in the next few years."

*Joseph L. Kovarik, MD  
January, 1984*

Originally, medical societies were organized to foster the interests of member physicians and the patients they serve. In the past such societies provided their members with professional and ethical guidelines and continuing medical education. The entry into the health system by a patient was usually through an individual physician who would then supervise or administer a specific course of treatment.

Medical societies were organized on a geographic basis with the various competing individual physicians as members. Most of these geographic organizations were on a county-wide basis and were then linked as component units into state medical associations. In turn, these associations were components of the national organization, the American Medical Association. In addition to focusing attention on the care and welfare of individual private patients, medical societies assumed public health roles at both the county and state levels in programs which provided medical care for indigent people through public hospitals and clinics, immunization programs, public health education, etc. The corporate practice of medicine was frowned upon and indeed was illegal in most states.

During recent years the traditional role of the medical society in its relationship with its members has been undergoing a dramatic change and is still evolving. No longer are medical societies the chief resource for continuing medical education, as this function has been largely taken over by professional societies and

hospitals. Government influence is affecting some of the long-standing functions of the medical societies, such as fee review and grievance committee activities. These activities have been abandoned in many areas because of fear of intervention by the Federal Trade Commission.

The biggest change the medical societies must address, however, comes from social and economic forces which are rapidly changing the methods of administering and paying for medical care. Much of this change has been fostered by a coalition of business and industry who have become increasingly concerned about the rising cost of health care and have fostered the development of HMOs, IPAs and PPOs.

While some may question whether such organizations actually do provide quality medical care at less cost, the fact that they are becoming a significant force is obvious. Currently there are 11 HMOs, IPAs or PPOs in the state of Colorado, while nationally, HMOs represent approximately seven percent of all patients with hospital insurance. Competition is frequently fierce among these provider organizations, and as the number of patients they enroll increases there is a resulting shrinking patient supply for physicians who are not allied with such organizations. Many physicians undoubtedly will opt to join one or more provider groups, although reluctantly, in order to survive.

Another important factor in this equation is the emergence of for-profit hospitals. Of the 6,900 general

*This article appeared in the January, 1984, issue of **Colorado Medicine**. From his perspective as a CMS Delegate to the AMA, this is how the picture looked to Dr. Kovarik just ten years ago this month.*



*Joseph L. Kovarik, MD*

hospitals in the United States today, almost one out of five is either owned or managed by a profit-making organization. This includes at least one university hospital, the University of Louisville's new medical center. This trend may significantly alter the traditional relationship of the medical staff to the hospital administration. In some areas the hospital medical staffs are closed and on salary.

The influence of the hospital on the practicing physician is also exemplified by the fact that there are some 400,000 practicing physicians in the United States and approximately ninety thousand already have some contractual relationship with a hospital. Many of these are relatively minor, such as EKG readers, but there is a proliferation of part-time and full-time positions which are filled in hospital emergency rooms, intensive care units, cardiovascular and GI laboratories, plus departments of anesthesia, pathology and radiology.

My prediction for the future is that more and more physicians will be participants in a provider organization which will offer prepaid (perhaps capitation) discount fee schedules and that competition among these organizations will increase significantly in the next few years. More and more physicians will accept salaried positions with a group, clinic or hospital in return for benefits such as guaranteed patient volume, malpractice and health insurance, vacations and educational benefits. Once we have allied ourselves with one or more of these provider groups, the era of the

physician as a private entrepreneur will be over. There will be few patients who are not committed to a specific plan purchased through their company or union. After we have been organized into these convenient groups, I believe the next step will be a consolidation of the HMOs, IPAs, PPOs and for-profit hospitals into several large health care organizations. These corporations will in turn provide for inpatient care, outpatient care, rehabilitation, home services, etc. and will market these services through their own insurance companies or marketing resources.

The next plausible sequence will be for several (perhaps six) multinational corporations to then take over this newly-organized health industry (so that IBM, for example, might purchase Humana, and General Motors might purchase Hospital Corporation of America) and operate them as the health care division of their diverse corporate activities. Each one of these giant corporations will then own and operate one thousand hospitals throughout the country with all health provider personnel on a salaried basis. If this comes to pass, this will mean that IBM, for example, or another such multinational, will be able to hire, fire and assign physicians to specific duties and geographic areas just as they currently deal with engineers, systems operators, etc. The physician, in this scenario, will remain a professional in the health field, but will be able to negotiate only for wages, hours and fringe benefits. While the possibility of such an evolution in the provision of health care is not pleasant to those of us

who have enjoyed independent private practice, this does not mean that it might not be attractive to medical students and residents in training who have not shared our perspective. The prospect of finishing a training program and being offered \$50,000 a year with no malpractice or office overhead expenses to worry about, and with vacations, educational opportunities and other fringe benefits provided, might not seem at all unattractive. In this type of salaried employment, these new physicians will also have an immediate patient supply and will not have to worry about struggling to build up a practice.

What does all of this have to do with medical societies? First, medical societies will have to consider reorganizing their base units of participation from the individual physician to the various groups to which the physicians are pledging their professional and financial allegiance. The AMA and some state and local societies have already recognized this fact by granting delegate status to hospital staff organizations, in addition to the traditional component society delegates. The American Group Practice Association, which represents 300 medical group practices with 14,000 physicians throughout the country has requested observer status in the House of Delegates and a request for delegate status may not be far in the future.

Because most patients will seek entry into the health delivery system through an organization or hospital, rather than through a private physician, the competition among these various groups can be expected to



## Competition

(Continued)

escalate. Already intense advertising, including newspaper and magazine ads, yellow pages of phone books, large billboards on streets and highways, and even radio and television promotions, can be seen throughout the country. As these provider groups mature it is apparent that they will take one or two forms. Either the hospitals will hire or contract with specific provider organizations and perhaps have physicians on salary, or physicians may organize their own group and in turn contract with specific hospitals to use their facilities. The Mayo Clinic is an outstanding example of this kind of relationship in which a medical practice group contracts with hospitals. The medical society will become a common meeting place for these various organizations to discuss common goals and problems. The California Medical Association has a new Department of

Contract Evaluation and Negotiating Services which functions as a clearing house on PPOs and contracting in general. This special unit has prepared a handbook listing 38 questions a physician should ask before joining a PPO or signing any other contract for the provision of professional services.

It seems reasonable that the medical society continue its role in setting and enforcing standards and ethics in the professional arena as well as providing a liaison with government organizations and programs, such as the FTC, Medicare, Medicaid, etc. at the national level. At the state level the medical society can provide a forum for hospital staffs and/or health organizations for deliberation of common issues and concerns, including such questions as possible participation in the provision of indigent care with local governments, state and county health department issues regarding specific projects, or public health in

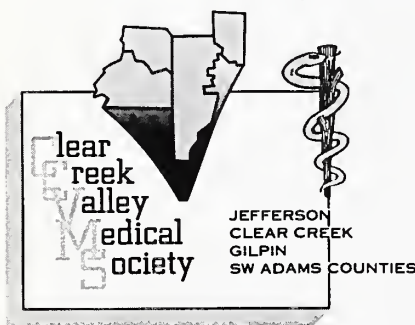
general. The same role can be envisioned at the county society level, especially since some county societies, such as Denver Medical Society are attempting to organize into IPAs and PPOs,

Whether we as individual physicians will have a significant impact on our future professional activities is a sobering question. If so, it is apparent that we will have to voice our concerns through an organized cooperative effort. Our individual opinions and efforts will be futile. We can only hope that organized medicine, exemplified by our medical societies, will be able to meet these challenges in a prudent and timely manner. It is imperative that we join, support and participate in our medical societies in order to retain some influence over the future of our profession and our professional obligations to the public we serve.

C/M

## Now, a public forum on health care that can mean something...

### Clear Creek Valley Medical Society Sponsors Grassroots Health Care Forums



Clear Creek Valley Medical Society is developing a series of public forums on health care to demonstrate a proactive and positive approach to the challenges of health care reform. The forums are intended to bring these important issues before the public and will provide an opportunity to give grassroots feedback to key health policy decision-makers in Colorado. Physicians as well as the general public are welcome to come and give input. A key feature of the forums will be a question/answer session from the floor to the panelists.

#### Forum #1: "The Benefits Package" 7 PM January 26, 1994 at Lakewood High School.

The program will be moderated by Clear Creek Valley Medical Society President H. A. Yocum, M.D., and will include four panelists: Senator Sally Hopper (R - District 13), Sherri Laubach M.D., Elizabeth Leif, Chair of the Benefits Committee of the Governor's Health Care Reform Initiative Task Force, and Gerry Rising, Past President of the Colorado Group Insurance Association. The second and third forums will be held in March and April.



By Robert Kruse, M.D.



The Primaries are over and now that President Clinton has released the Health Securities Act, the real action begins. I urge everyone in medicine to become more involved with our political process. It is apparent that some type of health care reform is on the horizon. The leadership of the AMA and its counterparts are actively involved in trying to guide this change. We all need to be team players.

Participating in politics is what makes our government work. The medical profession will be heard only through participating in an active exchange of ideas. The most important thing you can do is make a commitment to this process; thus I strongly encourage your membership in the Colorado Medical Political

Action Committee, (COMPAC).

COMPAC is a voluntary, political association to advance our shared interests and principles in medicine. The organization is actively involved with the American Medical Political Action Committee, (AMPAC). COMPAC supports those candidates amenable to the goals of organized medicine.

The advantages of becoming involved in COMPAC include:

- 1). Encourages increased participation in the political process by:
  - providing political/issue education
  - coordinating political activities for optimum impact
  - providing structure for active participation

—providing assurance that funds will be used effectively.

2) Provides avenues for free political expression and exchange of ideas.

3) Emphasizes cutting edge issues in medicine.

4) Serves as an effective effort in communication in our political process to individuals as well as our politicians.

5) Involves both the physician and his/her spouse directly in the political process.

We can sit on the sidelines and complain of government regulation and become victims of politics, or we can become an active part of the political process. By working together, we can make a difference in the future of medicine.



## SPOTLIGHT ON LEGISLATORS

Speaker of the Colorado House of Representatives **Chuck Berry** was raised in Colorado Springs and earned his Bachelor's Degree *Magna Cum Laude* from the University of Colorado prior to receiving his law degree from that same institution. Mr. Berry worked for three years each as Deputy District

Attorney for the 4th Judicial District and as Assistant County Attorney in El Paso County before being appointed El Paso County Attorney in 1981. He was first elected to the Colorado House of Representatives at age 34 and is now in his fifth term, including two terms as Speaker. Mr. Berry and his wife Maria Garcia Berry have three children.



Senate President **Tom Norton** was elected to the House of Representatives in 1986 and to the Senate in 1988. Mr. Norton is a professional engineer, with degrees from Colorado State University, and owner of a consulting engineering firm in Greeley. Senator Norton was the prime sponsor of Colorado's workers' compensation reform bill in 1991,

sponsored legislation protecting ground water quality and improving auto insurance, and was the sponsor of clean air legislation and Congressional redistricting. He has received numerous awards in recognition of public service and business/engineering achievements. Mr. Norton and his wife Kay have five children.



# The political process: a new order of medical practice

by Patrick J. Sullivan, MD  
Colorado State Representative



*Editor's Note: Rep. Sullivan's article was published in July, 1993, but the subject is of such a growing magnitude that we have chosen to repeat the article on the eve of a new legislative session.*

Access to medical care is a concern to all of us in the medical profession. It is also a concern for the population at large as represented in the legislature. What physicians consider access is not necessarily congruent with the thoughts of individual legislators.

An example of this is the law which legitimized lay midwives. Despite the best efforts of your lobbyists from the Colorado Medical Society, this bill finally passed and was signed by the Governor in 1993.

The arguments made by those favoring the bill centered around access in underserved areas like the San Luis Valley and the eastern plains of Colorado. They also stressed choice, lower costs and home delivery. Ultimately, after several years, the proponents of this bill and the lay midwives won. Quality of care as an issue did not prevail despite repeated testimony about the dangers to the mother and the baby.

A Good Samaritan amendment protests physicians who have to take care of the complications but attempts to mandate malpractice insurance for the lay midwife failed. A section requiring minimum training for the midwives was amended on.

There are similar movements afoot to allow more freedom to under-trained psychologists, etc., and as we know, chiropractors have long been fighting for and winning more medical privileges.

The reason these groups make inroads is not because of the purity of their intentions, nor the scientific

basis of their disciplines, but because they understand the political process and exploit it to the fullest. They have recognized the need, however unscientific, and dress this need as lower cost access. They understand the market and the political process where all too often we, as physicians, turn up our noses at the process.

This should in no way suggest that physicians should not fight for the principles of good health care. I have watched with pride as physicians have testified on issues that go to the very core of good medical practice. I have been particularly impressed by the leaders of the Colorado Medical Society (Dr. Leigh Truitt, CMS President during the 1993 legislative session). Leadership worked very hard during this past year to educate the legislature on health matters.

I have also cringed on occasion when a physician has preached at a committee hearing and has otherwise shown disdain for the legislative process; This is a sure prescription for losing an issue in the short term, and in the long run it paints a perception of arrogance if it is often repeated.

Passage of the lay midwife bill should teach us a lesson: ***If the medical profession is going to be a major player in shaping health care reform, it is imperative that more physicians become familiar with and involved in the political process.*** It is difficult when there is a busy practice to be managed, but in order to influence the process, more doctors must take an interest.

*"... not because of the purity of their intentions, nor the scientific basis of their disciplines, but because they understand the political process."*



## HIGHLIGHTS OF BOARD OF DIRECTORS MEETING - November 19, 1993

- Copic:** Dr. Howard announced that Copic had received a grant for a year long study with Harvard University regarding malpractice suits and patient payments.
- CMS Alliance:** Ms. Pam Laman, President, announced that Legislative Day would be February 28th. She also stated that \$500 had been contributed to AMA/ERF.
- AMA Delegation:** Dr. Levine reported that the AMA Interim Meeting would be held in New Orleans on December 5 - 8, 1993 and asked for BOD approval on two resolutions regarding Lifetime Learning Programs and the Dissolution of the Peer Review Program.
- Board of Directors:**
- The Board decided to not approve a recommendation to the BME from the Medical Practice Act Task Force which stated board certification was appropriate by a subspecialty board if that board was recognized by an ABMS member board as being within the scope of specialization of that ABMS member board.
- The Board reviewed a proposal from CFMC regarding the selection of physician advisors and independent examiners and recommended that the criteria requiring a minimum of twenty hours of part-time practice be retained.
- The Board approved a recommendation to the Organizational Study Committee that consideration be given to increasing the size of the Executive Committee to no more than eight members.
- The Board approved a letter from the Council on Legislation to the Legislative Sunrise/Sunset Review Committee stating that licensure for naturopaths must be governed by appropriate controls proving that naturopathic remedies are effective and safe for the purposes for which they are used.



# Women Speak Out



*Louise McDonald, M.D.  
Chair, CMS Women in  
Medicine Section*

"Offer me something my specialty society doesn't, and then I'll join." "I want time with my family, not organizations that spend my time and my money." "I'm not sure why CMS exists and what its continuing function could possibly be." According to replies to a questionnaire distributed by the CMS Women in

Medicine Section this past year, these are reasons why women physicians in Colorado avoid involvement in the Medical Society.

The November 15, 1993 issue of *American Medical News* reports that women outnumber men for the first time among first-year students at the West Virginia University School of Medicine. There are 45 women in the first-year class, and 43 men. The number of women physicians in the U.S. has nearly quadrupled during the past 20 years, but their representation in organized medicine hasn't risen accordingly. For example, 28% of the 6500 physicians practicing in Colorado are female, but women physicians comprise only 14% of CMS's membership. Looking at it differently, 86% of practicing male physicians in Colorado belong to CMS, but only 33% of practicing female physicians belong. Why?

In order to answer this question, to understand how female physicians view organized medicine, and to find out what female physicians want CMS to do for them, the Women in Medicine Section conducted a survey in Spring, 1993. Questionnaires were sent to 1100 Colorado female physicians: 600 CMS members and 500 non-members. The response rates were 36% and 12% respectively for a total of 297 replies.

The Women in Medicine Section had speculated that certain perceptions of medical societies might dissuade women from participating, but the survey did not confirm this hypothesis. The non-members who are familiar with CMS' position on issues such as abortion, discrimination, parental leave, and health care

reform are satisfied with those positions, and most indicated that changes in positions would not make them join. Interestingly, as many CMS women members as non-members view the Society as an "old boys' club". Most non-members do not seek to overcome this perceived fraternity aspect by joining the American Medical Women's Association (AMWA); 2/3 of the non-member respondents do not belong to AMWA.

So why don't more female physicians join CMS? The two most important reasons given are that dues are too high for benefits received and that similar or better benefits can be obtained through specialty societies. The specialty societies most often represented by the respondents are AAFP, AAP, ACOG, and APA. Many women stated that they had no time for organizations; some said that they simply were not "joiners"; and one made the point that "since women are paid less, dues should be less."

When non-members were asked if CMS could take ant action to persuade them to become members, the majority answered that they didn't know. However, many suggested a reduction in dues and an increase in benefits or more information about benefits; some suggested a program for residents; and several wished that CMS weren't totally private practice oriented. On the other hand, one queried, "Why pay dues to an organization with no goals that benefit the private practice of medicine?" Perhaps CMS needs to improve its communication to non-members about the nature of its activities and the benefits it offers. It

## The CMS Women in Medicine Section wants to know what motivates women physicians

certainly needs to reach more effectively those physicians who are not in private practice.

The majority of women physicians who answered the questionnaire are in solo practice or a partnership arrangement. About 20% are in fee-for-service or prepaid group practices; 15% are in government or other employed positions; and 8% are in academics. 59% of the CMS members have been members five years or less and 82% ten years or less—a young group on the whole. 73% of the respondents are married, with 34% married to physicians; 7% are divorced or separated; and 20% are single. Three women identified themselves as lesbians. 77% of the total respondents have children at home young enough to require care while they work. Most of the child care is provided through daytime help in the home, in daycare centers, or by outside baby-sitters. One of the respondents admitted that, “We tried everything; now I’m at home full time.” Indeed, when asked “What can the CMS Women in Medicine Section do for you?” a large majority replied that they need support for such issues as child care, parental leave, and part-time and job sharing positions. 82% stated that the time they can devote to medical practice is affected by their parental or home responsibilities. 54% are solely responsible for most of the chores at home.

From our own experiences and those related by our female colleagues, we on the Women in Medicine Section Council still believe that the time and energy

required to juggle practice and family life preclude active participation by many women physicians in any other activities, let alone organized medicine. However, the survey didn’t substantiate this impression. For example, 31% of women physicians with children at home consider themselves active in the state or local medical society compared to 29% of women physicians without children at home. 54% of survey respondents work between 36 and 65 hours per week; 17% work 0 to 5 hours per week; and 9% work 76 to 100 hours per week. There was no correlation between number or hours worked and active involvement in organized medicine.

The Section plans to use the questionnaire results to develop some of its projects. Membership recruitment must be aimed at young physicians—and must begin with the growing numbers of female medical students and residents. Women physicians who are not in private practice must be convinced of the benefits of joining the Medical Society. Women in academics must be included in these efforts; several academicians expressed the desire to link with community physicians with similar needs and requested support with academic career advancement.

The vast majority of respondents, both CMS members and non-members, believe it is important for women to hold leadership positions within organized medicine. Yet, most stated they don’t know if CMS provides women physicians with an adequate opportunity to achieve positions of leadership within the Society, and most don’t consider

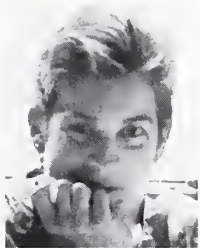
themselves active in organized medicine. Recognizing the need to convert a stated interest in leadership into an active role, the Women in Medicine Section must develop a plan to increase the number of women in leadership positions in CMS and component societies.

The questionnaire also revealed that Colorado women physicians want CMS to keep them informed about important health care issues and CMS activities, including positions on legislation, and to sponsor a mentorship program for female medical students and residents. 156 respondents indicated they are very interested in CMS’ pursuing a pro-choice position regarding abortion rights and 70 are somewhat interested. Many also requested practice management and financial advice. An overwhelming majority expressed the need for seminars or symposia on such issues as time/stress management, career/family conflicts, and leadership training.

The Women in Medicine Section welcomes suggestions from fellow physicians, both female and male, about how it can best serve women physicians and the Society as a whole. Indeed, CMS is an organization for all physicians, and the issues which affect the practice of medicine affect physicians of both sexes. However, as the survey demonstrates, some still unresolved issues affect women more than men. Although several respondents commented in the survey that they “don’t really care about women’s issues”, the majority care deeply. The CMS Women in Medicine Section is here to help.



# Parental Leave Policies



*In 1992, the Women in Medicine section suggested, and the house of delegates mandated that the WIM governing counsel investigate and develop guidelines for parental leave policies. During our research, the governing council members uncovered the fact that across the country there are very few formal policies in the medical system concerning parental leave. This includes residencies, private practice and academic centers. In Colorado, 28 percent of the practicing physicians in the state are female and it's likely that even a larger percentage of residents are female. Pregnancy among colleagues, residents, and employees is now a fact of the business world and the issues raised by parental leave will be more effectively addressed if dealt with proactively, rather than reactively. The guidelines enclosed in this issue of Colorado Medicine were approved. The Women in Medicine section welcomes any comments from the general membership concerning these guidelines. It is our hope that they will be useful to all physicians, both as employers and employees.*

**Ingrid Justin, MD**  
*Delegate  
 Women in Medicine Section*

## Family Leave Guidelines

### Group Practices Not Regulated by the Family and Medical Leave Act of 1993

1. Family leave should be gender neutral and used for the purpose of birth or adoption of a child, or severe illness of a child, spouse, or close relative. If both family members are practicing in the same group, they may not take leave at the same time.
2. Four months of leave should be allowed, not to be taken more frequently than once every 2 years. The leave must be taken within one year of the event and can be divided into increments of time.
3. The physician should have been practicing with the group for one year before eligibility for leave applies.
4. Leave may be unpaid or taken as vacation or sick leave.
5. Health, disability, and life insurance benefits should be paid by the practice for 2 months of the leave and by the individual for the remainder of the leave time.
6. Eligibility for retirement benefits should continue during the leave, but retirement benefits should not accrue.
7. Loss of seniority should not occur during the leave, but seniority should not accrue.
8. Family leave time cannot be borrowed in advance of that which has already been accrued.
9. The usual workload of a physician

on leave can be handled by the remaining physicians in the group working harder, hiring a locum, or working out improved cross-coverage arrangements.

10. Notification should be given to the group as soon as leave-taking is anticipated.

## Residency Programs

1. Family leave should be available for both female and male residents.
2. Family leave should be available for birth, adoption, or severe illness of a child.
3. A period of 6 weeks of paid leave per year should be made available for the above purposes. Leave may begin up to 2 weeks before delivery. An additional period of up to 4 weeks of sick leave may be taken for a complicated pregnancy and/or childbirth. The resident should not be required to use vacation or educational leave time for family leave but may use vacation or educational leave time for additional paid family leave, if desired. A period of 6 months combined paid and unpaid time leave time should be made available to the resident for the care of an infant or a sick child. A period of 3 months should be allowed with full health, disability, and life insurance benefits. After 3 months the resident should have the option of paying for his/her own benefits package.
4. Whenever possible, 6 months notification should be given, in writing, of the intention to take family leave to allow for appropriate scheduling arrangements.
5. If possible, the pregnant resident

## **"Pregnancy among colleagues, residents, and employees is now a fact of the business world."**

should be given the option of reduced work hours and less call towards the latter weeks of pregnancy (32-42 weeks gestation). Reduced hours should also be available if problems arise in the pregnancy during the vulnerable period for preterm birth (26-34 weeks). With early notification adjustment in call schedules may be effected without placing the entire burden on other program residents.

When leave is taken for the birth of a child, on return to work the resident should be given the option of reduced work hours per week (about 60 hours) for the purpose of adjusting to daycare providers and changes in breast feeding schedules.

6. Makeup time to fulfill residency requirements should be allowed in accordance with individual specialty Board demands. A minimum of 6 weeks per year for family leave should be allowed without having to be made up. The remainder of makeup time for unpaid leave should be paid and include full benefits.

### **Medical Students**

1. Family leave should be available for both female and male medical students.
2. Family leave should be available for birth, adoption, or severe illness of a child.
3. During the basic science years, attendance at lectures is not mandatory, and many medical students are able to study on their own and pass examination, continuing their medical education uninterrupted after having a child.

This option should be available to the medical student.

Alternatively, depending on the academic year, a student may elect to postpone his/her education until the following academic year with permission from the Dean of the School of Medicine.

Some medical schools offer basic science courses during the summer, and course work may also be made up using this option with approval by the Dean of the School of Medicine.

Under no circumstances will a medical student be allowed to graduate from medical school without satisfactory completion of all course work. Specific arrangements can be made with the Dean of the School of Medicine and with the Registrar.

4. During the third and fourth years vacation time usually consists of a six week block per year. This is true at the University of Colorado School of Medicine. Each block may be used individually, or the blocks may be combined for a total of 12 weeks. These blocks can be used for family leave. If greater than 12 weeks is desired by the student, the student will not be eligible to graduate with his/her class and will be required to complete all required clerkships prior to graduation. Specific arrangements should be given, in writing, to the Dean of the School and with the Registrar.
5. During family leave, the student should still be considered to be enrolled in the School of Medicine. Whenever possible, four months prior notification should be

*"In Colorado, 28 percent of the practicing physicians in the state are female and it's likely that even a larger percentage of residents are female."*

given, in writing, to the Dean of the School of Medicine of the intention to take family leave. Student health insurance and other benefits/memberships should continue during the leave period.

6. At the end of the family leave period, the student must return to course work on a full-time basis. Basic sciences students are not required to attend lectures but must attend required lab sessions and pass all examinations in accordance with course objectives provided by each course director. Clinical sciences students may return to required clerkships or may choose to enroll in an elective clerkship or research position that is less time demanding than the core clerkships provided that all requirements are completed prior to graduation.



# ColoradoCare

After reviewing Governor Romer's ColoradoCare proposal and comparing it to Colorado Medical Society policy, the CMS Health System Reform Committee developed the following position statement. This position has been approved by the CMS Board of Directors.

## CMS Position Statement on ColoradoCare

Based on information presented in the ColoradoCare Preliminary Feasibility Study, it is the position of the Colorado Medical Society (CMS) that there are many aspects of the ColoradoCare proposal which the medical profession supports. However, there are also numerous issues which raise concerns. This document outlines those areas of support and concern as they relate to the CMS health system reform priorities.

CMS views the following issues as the top priorities within health system reform:

- Providing universal access/coverage
- Improving quality of health care
- Preserving patient and physician relationships and choice
- Cost containment
- Maximizing administrative efficiencies
- Improving malpractice laws
- Developing realistic financing mechanisms

### Universal Access/Coverage

#### Support:

CMS commends ColoradoCare for its progress towards providing universal coverage for Coloradans and strongly supports efforts which accomplish this goal, including making coverage portable, eliminating preexisting condition exclusions and implementing mandatory

community rating. CMS concurs with the findings of the feasibility study that numerous non-financial barriers to access exist and supports efforts to eliminate such barriers. Some of these efforts include increasing the number of primary care physicians and increasing the number of practitioners in underserved areas.

#### Concerns:

CMS is concerned that providing access for certain populations is not adequately addressed in the report. These populations include residents of other states who are temporarily in Colorado (e.g. attending school), migrant workers, the homeless and other undocumented individuals. We are also concerned that there is no stated plan for incorporating workers' compensation and auto insurance into ColoradoCare. We understand and appreciate the complexities of incorporating these groups, especially workers' compensation. We encourage the inclusion of medical care for these groups in a statewide health system.

### Improving Quality of Health Care

#### Support:

CMS supports the concept of a comprehensive benefit package with emphasis on preventive care. We also support outcomes research for medical care as well as efforts to measure quality of health plans. CMS supports the concept of health plans sharing information on physician performance with practitioners in order to enhance and modify practice patterns through education.

#### Concerns:

Physicians are concerned that the state quality commission not be an arm of government, but an independently contracted entity. An impartial panel with physician representation should select this entity.

The feasibility study lists quality enhancement projects as an item under "ColoradoCare Program Costs" and states that quality management costs will be a relatively small part of overall program administration. We urge the state not to underestimate funding needed for quality improvement efforts. Sufficient funding for quality activities must be ensured up front and designated specifically for quality efforts.

Physicians believe that development and administration of quality indicators should be a cooperative effort with physicians playing a leading role. *Utilization management decisions should be based upon valid outcomes studies and should support high quality health care. Quality assessment should be conducted by physicians practicing within the state of Colorado, and also practicing within the same specialty as the physician being reviewed.*

Provider utilization and quality data must be properly interpreted so as not to present inaccurate or misleading information.

Physicians are very concerned that disincentives for providing appropriate care not be built into the system.

## **Preserving Patient and Physician Relationships and Choice**

### **Support:**

CMS supports the provision in ColoradoCare which allows individuals, rather than employers, to choose their specific health plan. This allows individual patients to continue in their ongoing patient-physician relationships, if desired, or to change to a plan which best meets their needs. Since the patient may change health plans annually, it provides for greater accountability for health plans to patients.

CMS supports ColoradoCare's pluralistic approach which allows consumers to choose among fee-for-service and various types of managed care plans, including point of service plans.

### **Concerns:**

ColoradoCare would create a health care delivery system dominated by a small number of large managed care entities. CMS does not support such a system. CMS is concerned about physicians being inappropriately excluded from participation in health plans in this new environment. CMS policy states that health plans have a right to set standards for entry into or continuation in their provider panels. Based on those standards, they are entitled to select with whom they will or will not contract. These standards must be made public and available to physicians prior to applying for membership on a panel. Physicians who are denied access into a panel or terminated from it must have the right to an appeal process.

## **Cost Containment**

### **Support:**

CMS supports ColoradoCare cost containment efforts which reduce costs by emphasizing preventive care as well as by restructuring incentives in the health care system, creating administrative efficiencies, making individuals more sensitive to the cost of their health care and creating a standard benefit package that will allow better cost comparisons.

### **Concerns:**

CMS has a strong concern that providers not assume a disproportionate share of cost containment responsibility. Participants at every level of the health care system - the state program administrator, health purchasing pools, health plans and providers - must all be held accountable for their costs. It is essential that the state administrator, purchasing pools and, particularly, health plans have incentives to control their administrative costs and not to rely on limiting provider reimbursement as a means of maintaining their budgets.

CMS has a number of other concerns regarding cost containment efforts proposed in the feasibility study including those listed below:

### **Managed Care**

ColoradoCare relies on managed care to a great extent to control costs. CMS is concerned about certain practices within managed care including the following:

- Physicians must be allowed to compete in what may be a health care delivery system dominated by a small number of large managed care entities. Therefore, provisions must be included that allow physicians collectively to negotiate with these entities.
- New provider-owned health plans should be allowed to organize and receive tax-exempt financing and perhaps special low-interest loans to enable them to compete with big insurers. Antitrust relief is also needed for this to occur.
- ColoradoCare must ensure that health plans make full disclosure to consumers regarding restrictions in access to health services within their plan.
- Disincentives for providing appropriate medical care must not exist.

## **Limited State Budget**

A significant problem with applying budgets to the health care system is that health care expenditures are not entirely predictable - sickness and disease are not fixed entities.

Consequently, determining an appropriate budget is extremely difficult. CMS supports research into health care expenditures to better define where money is spent, by whom and why.

CMS also believes that input from the medical profession is essential in the development of an adequate budget and that the profession should be an equal partner in the budget development process. Antitrust modifications must be made to allow for this partnership.

Adherence to a health care budget will by its nature require the limitation of health care. It is the opinion of CMS that it is society's role to make choices regarding the implementation of this limitation. True cost effective care must be emphasized. Physicians must retain their traditional role as patient advocate.

### **Price Controls**

ColoradoCare proposes the free market functioning. We support the notion that the free market system best ensures effective competition based on incentives to be efficient and to offer the highest quality at the lowest price.

### **Other Approaches**

CMS recommends study and development of other innovative approaches to cost containment such as Medisave accounts and other health IRA arrangements.

### **Maximizing Administrative Efficiencies**

#### **Support:**

CMS supports ColoradoCare proposals to make administration of the health care system more efficient



such as implementing electronic billing, standardizing data collection, standardizing eligibility verification, using community rating and eliminating underwriting.

#### Concerns:

While CMS supports the concept of purchasing pools to assist small businesses and individuals in purchasing insurance at reasonable cost, we are concerned about the control and power very large health insurance purchasing cooperatives could potentially acquire. We are concerned that this new bureaucracy could increase costs as opposed to controlling them. CMS is concerned that these purchasing cooperatives could easily evolve into a government-controlled single-payer system. CMS does not support this form of a health care system.

#### Improving Malpractice Laws

#### Support:

CMS strongly supports the

conclusion of ColoradoCare that malpractice reform is essential. We encourage continued strengthening of Colorado's tort reform laws and other alternative dispute resolution procedures. This might include further study of reduction of medical liability premiums and establishing an administrative versus tort system. CMS also supports the following specific provisions: 1.) a \$250,000 limit on noneconomic damages, 2.) periodic payment of future damages, 3.) a requirement that the jury hear evidence of any "collateral source" of compensation, and 4.) a reasonable sliding scale limit on attorney contingency fees.

#### Developing Realistic Financing Mechanisms

#### Support:

CMS supports the approach of using a multisource revenue base, i.e. a combination of Medicaid funds, employer/employee payroll taxes, alcohol and cigarette taxes.

#### Concerns:

CMS is very concerned about the ability to achieve appropriate and adequate funding for any health system reform proposal. If a global budget is implemented, there must be a plan to provide for cost overruns. Needed services must always be provided and providers must never be solely held financially responsible for them.

#### Conclusion

There are many aspects of ColoradoCare which the Colorado Medical Society supports. We look forward to discussing both our support as well as our concerns with policy makers and are committed to the process of debate and discussion. Colorado physicians are committed to delivering quality care and want to work with other decision-makers to develop positive solutions which ensure that all residents have access to the most appropriate and cost effective care.

## Correction

Please note the following corrections regarding the articles in the October issue of *Colorado Medicine* on the AMA-ERF and the CMS-ERF.

First, our sincere thanks to the Colorado Medical Society Alliance and especially Mrs. **Rose Pollard**, for submitting the article on AMA-ERF.

When retyped for the magazine, one important paragraph was left out. While AMA-ERF contributions fund four main funds, only three were listed: The Medical School Excellence Fund, the Development Fund and the Categorical Research Grant Fund. Omitted was the Medical Student Assistance Fund which must be used by medical schools to help students pay educational costs. This help may be in the form of loans, grants or scholarships and is presented at the discretion of the school. This fund is of vital importance and a large percentage of donations are designated for it.

It should also be stressed that contributions to both AMA and CMS-ERF are voluntary. The AMA-ERF

requests donations but no one is ever billed. Similarly, while CMS-ERF is shown on the dues statement, it is not a mandatory item.



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## Fast Paced Meeting in Store at IM '94

**T**he 1994 Interim Meeting of the Colorado Medical Society will be fast paced and exciting.

This is your chance to make a significant impact on organized medicine and the practice of medicine in Colorado with a minimum investment of time. In about a day and half, policies and positions which will affect the direction of the state's largest physician organization for the next six months to five years or more will be set. And we have structured the meeting to get the most input from our physician members.

### Crucial Opportunity

You will notice on the schedule (following page) that the House of Delegates opens Saturday morning, March 5. Reference Committees will meet Saturday afternoon and the House will wrap up its business by noon on Sunday. We have tried to provide you with an efficient use of your time and resources. You won't even have to miss office hours, unless you normally work on Saturday.

Here's the way your medical society works. Members and component societies sponsor resolutions which (after being checked out by our legal experts) go to the Reference Committees. They hear testimony on these subjects and make recommen-

dations to the House of Delegates. Then the House will cast its votes and the direction of your medical society will be set.

**I**t is during these few short meetings that all of the official policies and actions of the Colorado Medical Society are formulated. You should definitely attend. You have the chance to give your input at the county level in formulating resolutions, by testifying at the Reference Committee and by testifying in the House of Delegates.

### Other events

In addition to the main business meetings, there are several other events in which you may be interested.

The **Women in Medicine** Section will host a meeting Friday evening which is open to all female physicians in Colorado. As pointed out by Dr. Louise McDonald elsewhere in this issue, there are an increasing number of women physicians in Colorado and the medical society wants to be their united voice. This is your chance to see that women's issues are well represented in the deliberations of the medical society at large and to network with others who understand what you are going through.

The **Nominating Committee** will host an open forum Saturday morning for anyone who has been nominated or plans to run for office.

All nominations must go to this committee (including those who plan to run for reelection). In that connection, if you would like to nominate someone or be nominated for an elective office, now is the time to contact the committee. We will need a new President-Elect, a Vice Speaker of the House and several other positions. Call Mary Lee Johnston at the CMS or Dr. Dean Sadler, Chair of the Nominating Committee.

#### All Reference Committee

**Members** are urged to be at the briefing at 7:00 Saturday morning. This is a vital time of informing you how the process works and how to best fulfil your role as a member of a reference committee.

### Be There!

**C**ontact your county medical society for more information on who represents you in the House of Delegates. Sometimes there are even openings you can fill to help represent your fellow local physicians in the state society. If not, we urge you to communicate your views to your delegate, testify at the reference committee hearing and attend the meeting of the House of Delegates, if at all possible. You can gain insight into the workings of your medical society and make a positive difference on behalf of your patients and colleagues.



# Colorado Medical Society Tentative Interim Meeting Schedule

March 5-6, 1994  
Sheraton DTC Hotel, Denver, Colorado

## FRIDAY, MARCH 4, 1994

12:00 N .... 5:00 pm	Office open
11:00 am .. 1:00 pm	Finance Committee
1:00 pm .. 4:00 pm	Board of Directors
5:00 pm .. 7:00 pm	Registration
6:30 pm .. 9:30 pm	Women in Medicine

1:30 pm .. 4:00 pm

Reference Committee on Board  
of Directors/Constitution,  
Bylaws and Credentials  
Reference Committee on Health  
Affairs

3:30 pm .. 6:00 pm

## SATURDAY, MARCH 5, 1994

7:00 am 12:00 N	Office open
7:00 am .. 5:00 pm	Registration
7:00 am .. 8:30 am	Reference Committee Members
7:00 am .. 9:00 am	Nominating Committee Open Forum
8:30 am .. 9:00 am	Credentials Committee
9:00 am .. 9:30 am	House of Delegates Opening Session
9:30 am 11:45 am	General Membership Meeting
12:00 N .... 1:30 pm	Lunch

## SUNDAY, MARCH 6, 1994

7:00 am .. 2:00 pm  
7:00 am 11:00 am  
7:00 am .. 8:30 am  
7:00 am .. 8:30 am  
7:00 am .. 8:30 am  
7:00 am .. 8:30 am  
7:00 am .. 8:30 am  
7:00 am .. 8:30 am  
7:00 am .. 8:30 am  
7:00 am .. 8:30 am  
8:00 am .. 8:30 am  
8:30 am 12:00 N

Office open  
Registration  
Arapahoe caucus  
Aurora Adams caucus  
Boulder caucus  
Clear Creek Valley caucus  
Denver caucus  
El Paso caucus  
Larimer/Weld caucus  
Pueblo/Western Slope caucus  
Credentials Committee  
House of Delegates Closing  
Session

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# INTERIM MEETING REGISTRATION

1994 Interim Meeting of the Colorado Medical Society, March 5-6, 1994, Sheraton Denver Tech Center Hotel

Name (please type or print) \_\_\_\_\_

Name of Spouse/Guest (if attending) \_\_\_\_\_

Component Society \_\_\_\_\_ Office Phone \_\_\_\_\_

Please check all that apply

<input type="checkbox"/> Women in Medicine Section	<input type="checkbox"/> Young Physicians Section	<input type="checkbox"/> Resident Physicians Section	
<input type="checkbox"/> Component Society Executive	<input type="checkbox"/> Program Speaker	<input type="checkbox"/> Press	<input type="checkbox"/> Other _____

If you are not a member of CMS, please provide the following:

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Title \_\_\_\_\_

## Be sure to complete both sides of the form

## Send top part of form to CMS

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Organization Name **Colorado Medical Society**

Meeting Dates **March 5-6, 1994**

Q-Name \_\_\_\_\_

Guest Arrival Date \_\_\_\_\_

Guest Departure Date \_\_\_\_\_

No. of Persons \_\_\_\_\_

## Complete both sides before mailing



## RESERVATIONS FOR EVENTS AND MEETINGS

(Reservation deadline is February 18, 1994. Reservations accepted on a first-come, first-served basis.)

SATURDAY, MARCH 5, 1994

12 Noon-1:30 pm Luncheon

NUMBER OF  
RESERVATIONS

AMOUNT  
ENCLOSED

Complimentary

### HOTEL RESERVATIONS

Please use the hotel reservation form below to make your reservations directly with the Sheraton Denver Tech Center Hotel. **The deadline for room reservations is February 18, 1994.** The preferred rate will be extended to CMS members on a space available basis after February 18.

### MEETING REGISTRATION

**Please submit a registration form by February 18, 1994, if you plan to attend this Interim Meeting.** We're delighted to receive it by mail, fax, or phone. We can check you in more quickly and efficiently if you've preregistered, in addition to providing more accurate and therefore cost-saving guarantees for our food functions. Thanks!

### MESSAGES

For your convenience, a message board will be provided at the CMS registration desk. The hotel's phone number is 303-779-1100. (You may want to leave this number with someone). If you need to be contacted, ask the hotel operator to transfer the call to the CMS registration desk or CMS office.

### WHAT TO DO

Complete both sides and return to Colorado Medical Society, PO Box 17550, Denver, CO 80217 (303-779-5455 or 1-800-654-5653), or FAX to 303-771-8657.

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Signature \_\_\_\_\_

Confirmation is based on scheduled arrival date availability. All rates subject to tax. Currently 11.8%.

**Request and deposit must be received by February 18, 1994.** Deposit refunded if cancellation is received 48 hours prior to arrival. Check-in time and guest room availability are 4:00 p.m. Checkout time is 1:00 p.m. Please arrange travel plans accordingly. Baggage storage available for earlier arrival.

# 1994 Secretary of Health's Community Health Promotion Awards

Every two years, the U.S. Secretary of Health seeks nominations for their Community Health Promotion Awards. The Secretary of Health searches for community programs and outstanding volunteers throughout our nation.

Last year's winners included the Drive Smart program of El Paso County as well as Partners in Prenatal Services of Pueblo County. In the category of outstanding individuals, Mary Alexander, a volunteer with the Tri-County Health Department was recognized for her efforts. Winners were honored by Governor Romer during Colorado Public Health Week.

## Who is eligible for nomination as an outstanding individual?

The nomination should show that the nominee has been involved in voluntary activity geared to promoting health and advocating healthy behavior in low income/minority communities. The activity should have been performed over a sustained period of time and the nomination should demonstrate, if possible, the extent to which the activity has contributed to a successful outcome in terms of changes in community/specific population behavior. This individual's activities should reflect a sensitivity for special populations including the elderly, minorities, pregnant women and infants, and the economically disadvantaged.

Outstanding community health promotion programs should come from the following organizations:

- Health departments

- Professional groups
- Youth groups
- Civic Organizations
- Voluntary agencies
- Public and private schools
- Private sector community groups
- Industries
- Colleges and Universities
- Health care institutions

Outstanding programs that are submitted for nomination should demonstrate that program objectives are based on well-defined problems derived from baseline data and/or evidence of community need. It should show evidence of collaborative efforts with other private or public agencies or groups (e.g., volunteer agencies, schools, universities, or businesses) for planning, implementation, and evaluation. In addition, the program should give evidence that objectives and intervention strategies are appropriate, well conceived, and effectively implemented. There must be evidence of creativity, potential for replication/dissemination and an agency or community commitment to continue the project or part of it.

For nomination forms, call Jackie Starr-Bocian, Colorado Department of Health, Division of Prevention Programs at (303) 692-2503. Nomination must be received no later than January 14, 1994. Nominate a program today. Help shine the spotlight on a health promotion program or outstanding volunteer in your community!

***Nomination Deadline is  
January 14.***



# MRSA Protocol for Long Term Care Facilities

## Introduction:

A suggested protocol has been developed for managing Methicillin-Resistant *Staphylococcus Aureus* (MRSA) on a county wide level in long term care facilities (LTCF). It was developed by medical directors of LTCF in El Paso County in conjunction with infectious disease physicians practicing in area acute care facilities. It was subsequently reviewed and approved by the Ad Hoc Committee on Nursing Home Care and the Board of Directors of the Colorado Medical Society.

This protocol is designed to set a standard for the care of LTCF residents. However, it is not intended to mandate treatment. The coordination of this standard between the LTCFs and acute care hospitals will provide a reasonable approach to the containment and treatment of MRSA and is intended to dispel the need for unwarranted isolation, expense and medication use.

MRSA are strains of *Staph Aureus* which are resistant to Methicillin and related drugs. The organism itself has the same virulence (and lack of virulence) that community isolated SA strains have. It is found in areas where SA is found (*skin, anterior nares, respiratory tract*). It colonizes LTCF residents at a given level which varies from facility to facility. Colonization itself is not detrimental to the health of an individual. This organism becomes clinically important when it infects wounds, the respiratory system or the urinary tract.

Most commonly MRSA is transmitted between individuals by direct contact. Therefore, in general, hand washing between the care of residents is the most effective means to prevent the spread of this bacteria. Isolation protocol for infected individuals will be discussed below.

Treatment considerations of clinically significant conditions require simultaneous treatment of the skin and anterior nares.

## Part 1: Care of Individuals with MRSA Infection

- A. Sputum culture positive for MRSA
  1. Sputum positive individuals (when sputum is collected properly) may reflect clinically significant infections such as pneumonia, bronchitis, etc. The full clinical picture depends on the physical examination, the white count, and a chest x-ray. This protocol also includes individuals with tracheostomy sites infected with MRSA.
  2. Clinically significant infection with MRSA requires systemic treatment with antibiotics. In addition, a daily total body bath with chlorhexidine (Hibiclens) and twice a day application of mupirocin (Bactroban) ointment to the anterior nares is strongly recommended for seven (7) days.
  3. Treatment can be terminated after two (2) sputum cultures document the absence of MRSA. These cultures should be obtained 48 hours after the completion of antibiotics and cultures should be obtained 24 hours apart from each other.
  4. Isolation procedures would include private room as well as staff using gloves, hand washing, mask with eye protection, and gown. Cohort pairing (another individual known to have MRSA) is acceptable. Isolation can be discontinued when sputum cultures document the absence of MRSA (See Part 1, A3). The most effective means to prevent aerosolization of MRSA when resident is actively coughing and staff is in the room is for the resident to wear a mask. Applying a mask to the resident in his or her room can be frightening and should be avoided unless persistent coughing causes concern. Resident may be transported to common areas (such as showers) if the resident wears a mask.
- B. Care of individuals with MRSA infected wounds
  1. Wounds (other than pressure sores) with purulent drainage should be cultured. Pressure sores are generally not cultured as cultures reflect skin flora rather than infecting organisms. Infecting organisms from pressure sores are more commonly isolated from cultures obtained after deep surgical debridement.
  2. Wounds infected with MRSA are generally treated with systemic antibiotics (such as IV Vancomycin) and topically applied medication. Treatment with daily total body bathing with chlorhexidine (Hibiclens) and twice daily application of mupirocin (Bactroban) ointment to the anterior nares is strongly recommended.
  3. Treatment continues at least seven (7) days and can be terminated after two wound cultures document the

absence of MRSA. These cultures should be obtained 48 hours after the completion of antibiotics and cultures should be obtained 24 hours apart from each other.

4. Isolation in a private room is helpful but not necessary. Cohort pairing (another individual known to have MRSA) is acceptable. Gloves and good hand washing are mandatory. A gown should be used when wound contact is anticipated. Isolation procedures can be terminated after two cultures are negative for MRSA (see Part 2, C). Resident may be transported to common areas (such as showers) provided the wound is covered.

C. MRSA isolated from the urine

1. MRSA isolated from the urine in individuals *without* an indwelling Foley denotes the possibility of sepsis and should be worked up appropriately. Cellulitis, pressure sores, carbuncles, and indwelling lines are possible etiologies for such sepsis. MRSA sepsis is generally treated with IV Vancomycin, but in certain circumstances can be treated with trimethoprim/sulfa (Septra, Bactrim). Treatment should also include daily bathing with chlorhexidine (Hibiclens) and twice daily application of mupirocin (Bactroban) ointment to the anterior nares for seven (7) days. Universal precautions should be followed until two (2) urine cultures are negative for MRSA. These cultures should be obtained 48 hours after the completion of antibiotics and cultures should be obtained 24 hours apart from each other.
2. MRSA isolated from the urine in residents *with* indwelling Foley catheters is a complex clinical problem. This can represent either colonization of the Foley catheter, cystitis, or MRSA-sepsis, and requires medical scrutiny. The intensity of the medical workup depends upon the resident's clinical presentation. Minimal treatment includes: changing the Foley catheter and systemic antibiotics. In addition, daily bathing with chlorhexidine (Hibiclens) and twice daily application of mupirocin (Bactroban) ointment to the anterior nares should be carried out for seven (7) days. Universal precautions are also suggested until two (2) urine cultures are negative for MRSA. These cultures should be obtained 48 hours after the comple-

tion of antibiotics and cultures should be obtained 24 hours apart from each other.

- D. Individuals with MRSA cultures from the anterior nares or individuals with MRSA cultured from the skin who do not have significant clinical infection (i.e. resident who is colonized with MRSA). These individuals would have been cultured because of an outbreak investigation.
  1. Treatment is recommended for MRSA colonized individuals during an outbreak of clinical disease. This is particularly true for those who are at increased risk for subsequent infection such as residents with diabetes, immunosuppressed residents, and residents with indwelling IV lines or Foley catheter.
  2. Treatment includes daily total body bathing with chlorhexidine (Hibiclens) and twice daily application of mupirocin (Bactroban) ointment to the anterior nares for seven (7) days. Reculture is not necessary. Systemic antibiotic is not necessary and ineffective.
  3. Isolation is not necessary. However, good hand washing by LTCF staff is imperative.
  4. Individuals with non-MRSA SA cultured from the anterior nares or skin should not be treated.

## Part 2: Workup for MRSA Epidemics in the LTCF

- A. Cultures of the anterior nares and skin should only be performed during outbreaks of MRSA. An epidemic outbreak of MRSA is defined as two (2) or more cases of *clinically significant* MRSA occurring in the same general area within a period of seven (7) days.
- B. A facility generated protocol should be in place before the collection of cultures to ensure privacy of results and appropriate epidemiological protocol. Only residents residing in the affected area of the facility should be cultured. Staff who are symptomatic or epidemiologically linked should also be cultured. It is imperative that the medical director for the facility be involved in the design and supervision of the protocol, as well as the interpretation of the data. A team meeting would be beneficial to study the results and design preventive procedures for the facility. An educational process for the staff and families should be implemented both during and after the study.

- C. During a MRSA epidemic, if feasible, there should be cohorting of MRSA residents, with physical separation of positive patients and no staff cross-over to MRSA negative patients. Two consecutive negative cultures 24 hours apart and at least 48 hours after completion of antibiotics are grounds for release from the cohort.

## Part 3: Transferring residents with MRSA infection to acute care facilities and their return to the LTCF

- A. Colonization of an individual with MRSA should not prevent the transfer of that individual between facilities. However, prior notification is strongly recommended.
- B. Transfer of an individual from a LTCF to the acute care facility is based solely on the individual's clinical status.
- C. Return of an individual from the acute care facility to the LTCF is based solely on the individual's clinical improvement.
- D. It is advised that ambulance personnel transferring residents to and from LTCF maintain the standard (and only the standard) of isolation carried out at the initiating facility.

## Part 4: Protocol for LTCF Staff

- A. Staff who are epidemiologically associated with residents infected with MRSA must be treated by their primary physicians as directed in Part 1, D2.
- B. Individuals with respiratory or wound cultured MRSA should be treated by their primary physicians and not return to clinical responsibility until cleared by their physicians.
- C. Reassigning staff has been done in other states.

## Part 5: If a resident (or guardian) refuses treatment

- A. It is the right of individuals in LTCF to refuse treatment of their particular medical problems.
- B. If a resident (or guardian) refuses treatment, their wishes should be respected. It is then the responsibility of the facility to maintain appropriate containment (as mentioned above) to protect staff and other residents.



# T

# ake back health care!

*"...this is an **independent provider association**, not an **independent practice association**."*

This is an update on the current status of the feasibility study of an independent provider association for an accountable health plan. This was authorized by Resolution 42A of the House of Delegates of the Colorado Medical Society in September, 1993. The need for "not-for-profit, community-based health plans" has since been eloquently stated by Arnold Relman in *"Medical Practice Under the Clinton Reforms -- Avoiding Domination by Business."*

This study is a low budget effort relying primarily on the resources of the CMS staff rather than independent consultants. To this point we have invested in an anti-trust analysis by our counsel, Robert Montgomery of Montgomery, Little, as authorized by the resolution. To date, based on very little information about the organizational structure of the IPA, his opinion is that there are no absolute antitrust barriers. A final determination, of course, depends on a detailed review of the organization still to be designed.

If you paid careful attention to the title of this update, you noticed that this is an **independent provider association**, not an **independent practice association**. This tells you that the association would be open to other providers of health care on a non-exclusive basis, notably hospitals, home care, pharmacies, etc. We all need open access to patients. Competitive bidding and exclusive contracting harm all providers.

On November 23, 1993, we held a meeting at the CMS offices to discuss this concept with physicians, hospitals, home care agencies, pharmacies, the Division of Insur-

ance, the Department of Social Services, legislators and others concerned with health care in Colorado. The response and turnout were enthusiastic, considering the snowy day. Most importantly, no one suggested that this was a bad idea, or that there were significant legal or practical obstacles.

We are going ahead with an analysis of the various legal forms that this organization could take. Although we have considered alternative legal entities such as cooperatives and for-profit corporations, our best judgment at this time is that we should incorporate as a not-for-profit in which individual providers would purchase memberships. Our fundamental philosophy is that physicians should make money through practicing medicine rather than through equity investments in health care.

I would like to remind you that we are entering into this effort because we believe that it will benefit both the providers and the recipients of health care. For this reason, we are establishing certain principles that we hope will improve both the quality of and the access to care for all the people of Colorado.

- Open access to the plan for all providers who can meet the need for high quality, cost effective health care.
- Open access to care for all people of Colorado assured by Medicare/Medicaid mandatory participation and means tested fee schedules.

If some of these principles seem familiar, you may recognize why. One of the most astute observers of health care reform commented

# A status report on the Independent Provider Association Task Force

by Leigh Truitt, M.D.  
Chairman  
IPA Task Force



early on that we were trying to create a single payer system. The significant difference is that this would be managed by the providers, not by the government, and would compete with other more exclusive accountable health plans.

A meeting of our Physician IPA Task Force will have taken place on December 13th. The members of the task force are included here.

We are preparing a Request For Proposals to send to the insurers and HMOs of Colorado to find a joint venture partner for our accountable health plan. We are also considering an application to the Robert Wood Johnson Foundation for funding a study of means tested fee schedules.

Please let me hear from you. I am convinced that this project is feasible if the physicians of Colorado want to make it happen. No one else among the provider community can do this. Let us **"take back"** health care! We can no longer allow others to set the rules and own the patients. It is not enough to practice good medicine and leave the economics to others. We must seize the high ground in the interests of our patients and ourselves.

## IPA Task Force

Leigh Truitt, MD, Chair  
Arapahoe

John V. Buglewicz, MD  
Fremont County

Tom Dunn, MD  
Weld County

William Ezell, MD  
Larimer County

John Farrington, MD  
Boulder County

John Fox, MD  
Northeast Rural

Barton Goldman, MD  
Arapahoe

David Greenberg, MD  
Arapahoe

Mary Jo Jacobs, MD  
Denver

Joel M. Karlin, MD  
Clear Creek Valley

Muryl Laman, MD  
Pueblo County

David Martz, MD  
El Paso County

William Varani, MD  
Arapahoe

Roger Shenkel, MD  
Mesa County

Chris Unrein, DO  
Huerfano County

### Ex-Officio

Wm. Carl Bailey, M.D.  
President, CMS  
Denver

Robert Montgomery  
Michael Smith  
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Attorneys at Law

### Staff

Sandi Maloney  
Edie Register  
Jo Parkin

#### **References:**

1. *The New England Journal of Medicine*, 329:1574-1576, November 18, 1993.





## DEFINITIONS

The definition of terms in health care financing and of terms related to delivery, provision and evaluation of care. *Colorado Medicine* suggests you keep these monthly articles and definitions, even though many will change, some will disappear and new ones will appear as the health system reform unfolds.

### Terms related to financing health care

**APPROPRIATION**-In Federal and State budgets, an act of legislation that permits Federal and State agencies to incur obligations and to make payments out of the Treasury for specified purposes. An appropriation usually follows enactment of authorizing legislation. An appropriation is the most common form of budget authority, but in some cases the authorizing legislation provides the budget authority. Appropriations are categorized by their period of availability (one-year, multiple-year, no-year), the timing of legislative action (current, permanent), and how the amount of the appropriation is determined (definite, indefinite).

**CHARGES/COSTS**-Prices assigned to units of medical service, such as a visit to a physician or a day in a hospital. Charges for services may not be related to the actual costs of providing the services. Further, the methods by which charges are related to costs vary substantially from service to service and institution to institution. Different third party payers may require use of different methods of determining either charges or costs. Charges for one service provided by an institution are often used to subsidize the costs of other services. Charges to one type or group of patients may also be used to subsidize the costs of providing services to other groups.

**COMMUNITY RATING**-A method of establishing premiums for health insurance in which the premium is based on the average cost of actual or anticipated health care used by all subscribers in a specific geographic area or industry and does not vary for different groups or subgroups of subscribers or with such variables as the group's claims experience, age, sex, or health status. The Health Maintenance Organization (HMO) Act defines community rating as a system of fixing rates of payments for health services which may be determined on a person or per family basis "and may vary with the number of persons in a family, but must be equivalent for all individuals and for all families with similar compositions." The intent of community rating is to spread the cost of illness evenly over all subscribers (the whole community) rather than charging the sick more than the healthy for health insurance. Community rating is the exceptional means of establishing health insurance premiums in the United States today.

**COPAYMENT**-A type of cost sharing whereby insured or covered persons pay a specified flat amount per unit of service or unit of time (e.g., \$2 per visit, \$10 per inpatient hospital day), their insurer paying the rest of the cost. The copayment is incurred at the time the service is used. The amount paid does not vary with the cost of the service (unlike coinsurance, which is payment of some percentage of the cost).

**COVERED SERVICES**-All benefit packages have a defined set of basic benefits. In managed care, there are specific limitations on what is covered.

**MEDICALLY INDIGENT PROGRAM** - a program to serve a person who is too impoverished to meet his medical expenses. It may refer to either persons whose income is low enough that they can pay for their basic living costs but not their routine medical care, or alternately, to persons with generally adequate income who suddenly face catastrophically large medical bills.

**THIRD PARTY ADMINISTRATOR** - an organization that pays health or medical expenses on behalf of beneficiaries. The TPA pays bills on the patient's behalf; such payments are called third party payments and are distinguished by the separation between the individual receiving the service (the first party), the individual or institution providing it (the second party) and the organization paying for it (the third party).

### Terms related to Providing Care

**CONSULTATION**-The act of requesting advice from another provider, usually a specialist, regarding diagnosis and/or treatment of a patient. The consultant usually reviews the history, examines the patient, and then provides a written or oral opinion to the requesting

practitioner. Referral for consultation should be distinguished from referral for service because responsibility for patient care is not usually delegated to the consultant. This definition distinguishes a consultation between providers from an encounter or visit between a provider and a consumer.

**CUSTODIAL CARE**-Board, room, and other personal assistance services generally provided on a long-term basis, which do not include a medical component. Such services are generally not paid for under private or public health insurance or medical care programs except as incidental to medical care which a hospital or nursing home inpatient receives.

**EMERGENCY CARE**-Care for patients with severe, life-threatening, or potentially disabling conditions that require intervention within minutes or hours. Most hospitals and programs providing emergency care are also asked to provide care for many conditions which providers would not consider as emergencies, suggesting that consumers define the term more nearly synonymously with primary care and use such programs as screening clinics.

**HOME CARE**-Health services rendered to an individual as needed in the home. Such services are provided to aged, disabled, or sick or convalescent individuals who do not need institutional care. The services may be provided by a visiting nurse association, home health agency, hospital or other organized community group. They may be quite specialized or comprehensive (nursing services, speech, physical, occupational and rehabilitation therapy, homemaker services, and social services).

**IMAGING SERVICES**-The production of a picture, image, or shadow that represents the object being investigated. In diagnostic medicine the classic technique for imaging is x-ray. Newer techniques involve the use of computer-generated

images produced by x-ray, ultrasound, or infrared.

**INPATIENT CARE**-Care rendered to a patient who has been admitted at least overnight to a hospital or other health facility (which is therefore responsible for his room and board) for the purpose of receiving diagnostic, treatment or other health services.

**LONG-TERM CARE**-Health and/or personal care services required by persons who are chronically ill, aged, disabled, or retarded, in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals. Ambulatory services, like home health care, which also can be provided on a long-term basis, are seen as alternatives to long-term institutional care.

**NURSING CARE**-Care intended to assist an individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. This includes assisting patients in carrying out therapeutic plans initiated by physicians and other health professionals and assisting other members of the medical teams in performing the nursing function and understanding health needs of patients. The specific content of nursing care varies in different countries and situations, and it is important to note that, as defined, it is not given solely by nurses but also by many other health workers.

**PEDIATRIC CARE**-Medical care relating to care of children and treatment of their diseases. This care is usually rendered by a specialist in the treatment of children's disease, a pediatrician.

**PHYSICAL MEDICINE**-The use of physical agents, biomechanical, and neurophysiological principles and

assistive devices in relieving pain, restoring maximum function, and preventing disability following disease, injury or loss of a bodily part.

**PRENATAL CARE**-Care of the woman during the period of gestation. This consists of periodic examinations for determination of blood pressure, weight, changes in the size of the uterus, condition of the fetus; urinalysis; instruction in nutritional requirements, preparation for labor and delivery, care of the newborn; and provision of suggestions and support to deal with the discomforts of pregnancy. Scheduled visits at regular intervals offer the opportunity to detect any untoward changes in the condition of the mother so that necessary treatment can be instituted.

**PREVENTIVE CARE**-Care which has the aim of preventing disease and its consequences. It includes health care programs aimed at warding off illnesses (e.g., immunizations), early detection of disease (e.g., Pap smears), and inhibiting further deterioration of the body (e.g., exercise or prophylactic surgery). Preventive medicine developed subsequent to bacteriology, and was concerned in its early history with specific medical control measures taken against the agents of infectious diseases. With increasing knowledge of nutritional, malignant and other chronic diseases, the scope of preventive medicine has been extended. It is now operatively assumed that most if not all problems are preventable at some stage of their development. Preventive medicine is also concerned with general preventive measures aimed at improving the healthfulness of our environment and our relation with it through such things as avoidance of hazardous substances, modified diet, and family planning.

*(Will be continued next month)*



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## DEA Registration Fees Almost Quadrupled

The Colorado Medical Society has received numerous calls from physicians regarding the recent increase in fees for obtaining Controlled Substance Registration Certificates. There has been some concern expressed. We contacted the DEA's offices and were informed that in October 1992, the United States Congress passed the Department of Justice and Related Agencies Appropriations Bill of 1993 (Public Law 102-395). In this massive appropriations bill, one provision requires that the Drug Enforcement Administration raise its application fees to recover the costs of its Diversion Control Program.

The Diversion Control Program investigates "diversion" of controlled substances. Basically that means you're being charged a fee for an investigation to find out if you're abusing the system. One physician described it as similar to collecting fees from teachers to build schools. Someone else said "It's like paying the IRS to audit you."

Based on the requirements of the law, the new application fees for DEA registrations are as follows:

Practitioner ... For three years	\$210
Retail Pharmacy .....	\$210
Hospital/Clinic .....	\$210
Teaching Institution .....	\$210
Researcher .....	One Year \$70
Analytical Laboratory .....	\$70.
Narcotic Treatment Prog. ....	\$70.
Importer .....	\$438.

Exporter .....	\$438.
Distributor .....	\$438.
Manufacturer .....	\$875

### DEA to Reissue 30,000 Registration Certificates

The Drug Enforcement Administration (DEA) has agreed to reissue some 30,000 recently issued controlled substances registration certificates at the request of the American Medical Association. These certificates incorrectly reflect that a \$60 fee was paid. In fact, these registrants paid the DEA's newly increased \$210 fee.

Upon learning of the DEA's error, the AMA immediately complained to the agency. A pending lawsuit by the AMA could result in a partial fee refund. Inaccurate records of who has paid the higher fee would make it difficult to distribute any refund.

Physicians who received an incorrect DEA registration certificate do not need to take any action. New correct certificates should be mailed in the next few weeks, according to the DEA.

### AMA, Other Groups Challenge DEA's New Registration Fees

In a lawsuit filed on 6/11/93 the AMA and other health care groups challenge the new registration fees imposed by the Drug Enforcement Administration. Joining in the suit are the American Osteopathic Association, American Dental Association, National Wholesale Druggists' Association, and National Association of Retail Druggists.

A final rule issued by the DEA on March 22 nearly quadrupled registration fees for those who manufacture, distribute, prescribe or dispense controlled substances. The purpose of the fees is to fund a drug Diversion Control Program. The AMA complaint contends that the DEA violated federal law in issuing the final rule.

The AMA and its co-plaintiffs are in support of the DEA's efforts to stop the illegal diversion of controlled substances, and physicians are willing to do their part, including paying reasonable registration fees, to assist in the program. However, the lawsuit contends that the final rule issued by the DEA is not an act of responsible government; that does not comply with federal law.

The lawsuit alleges that nowhere in the final rule did the DEA (1) define the nature, scope, and operations of the Diversion Control Program; (2) explain the relationship, if any, between the Diversion Control Program and the activities of those required to pay registration fees; (3) justify the large increase in registration fees designed to support the Diversion Control Program; or (4) justify the DEA's allocation of these fees among the various categories of registrants.

Colorado Rural Health Resource Center Works to Improve Access to Quality Health Care in Rural Colorado.





### Center Targets Rural Health Care Shortages

Established in 1991 by members of the Rural Health Consortium, the Rural Health Resource Center's stated mission is, "To improve access to quality health care in rural Colorado by creating a focal point for information and coordinating rural health care resources."

The Center offers opportunities for rural and urban health care providers to:

- share information on rural health issues in Colorado and the country
- participate in health-related activities
- coordinate resources
- provide input and recommendations toward resolving rural health problems statewide
- learn about programs and resources that are available to address rural health problems
- work with other agencies to address the shortage of health care providers in Colorado's rural areas

The Center additionally provides technical assistance to rural communities so they can take full advantage of federal, state, public and private resources.

Membership to the Colorado Rural Health Resource Center is open to individuals and organizations. Individual members are entitled to one vote; organizational members must designate a voting representative. Membership dues are

\$25 for individuals and \$100 for organizations. Payment of dues provides membership status for one year, beginning either January 1 or July 1. Meetings are held every other month, usually in Denver.

For further information write to the Colorado Rural Health Resource Center, FCHSD-RPH-A4, 4300 Cherry Creek Drive South, Denver, CO 80222-1530 or call 692-2476.

### CPR Directives Not Clearly Understood

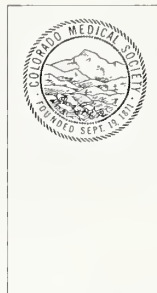
It has come to our attention that there is a lack of knowledge resulting in misuse of the CPR Directives by physician's offices, hospitals and other medical facilities across the state. As the administrator of this program for the state of Colorado we offer the following information and suggestions for their use.

#### Instructions for Completing the CPR Directive Forms (for use by health care providers)

1. **Choose the correct form for the patient.** The **patient directive** is to be used for those persons who are capable of making their own decisions regarding CPR. The **authorized agent directive** is to be used by an agent chosen to make health care decisions for some one who lacks decisional capacity to make such decisions.
2. **This directive is a legal document.** Be sure that the names are legible. If in doubt, reprint or type the name again beside the illegible name. Press hard so that all three copies are readable. The pink copy must be read by the bracelet/necklace vendor. All

spaces need to be completed. Be sure to include the physician's license number.

3. **Do not release uncompleted forms to patients or authorized agents.** The forms are numbered and each physician or facility is responsible for those that they purchase. These forms are to be completed in the presence of the physician who will be signing the form (or his/her designee). **Counseling with the patient or the authorized agent by the physician or his/her designee, should take place** at this time to assure that the consequences of signing such a directive are clear. The CPR Directive is for persons for whom death is not unexpected nor unwelcomed. Those who wish to avoid long term life support should use a living will or a medical durable power of attorney to convey their wishes.
4. **The physician should not pre-sign the forms.** The patient or his/her agent is to sign the directive first in the presence of the physician or his/her designee. The physician must sign the form and does so only after it is signed by the declarant or his/her agent.
5. The **original form** is to go the patient or the authorized agent. **This is the legal directive.** It should be kept in a safe place or carried by the person to whom it applies if no necklace or bracelet is worn. Relatives or close friends should be notified of its existence and where it is kept.
6. The **yellow copy** is to be kept in



the patient's medical record.

7. The **pink copy** is to be mailed by the patient with the order form for the necklace or bracelet.

**Give each person who signs a CPR directive an order form for a bracelet or necklace.** The patient or his/her authorized agent is responsible for ordering the necklace or bracelet. The number that appears on the written document will also appear on the necklace or bracelet.

- 8 **This directive can be revoked** only by the declarant or authorized agent by destroying the original document and the necklace or bracelet (if purchased), or by the declarant or his/her agent stating that revocation is desired. The physician should be notified of this decision so that the yellow copy can be removed from the medical record. **Appropriate documentation should be noted in the patient's medical record of this revocation.**

9. **Physicians who act as authorized agents** are encouraged to have a second physician sign the directive as the attending physician.

The Colorado Medical Society is only authorized to make CPR Directive forms available to physicians, hospitals, home health agencies or other facilities that are licensed, certified or otherwise authorized to administer medical treatment. **The purpose for limiting the distribution points for these forms is to ensure, to the degree possible, that a health care provider**

**counsels individuals as to the consequences of having a CPR directive and then signs the directive should the patient choose to execute such a document.** However, some of the facilities authorized to receive these forms do not have health care providers on site. The forms are then given directly to individuals for them to take to their own health care providers. This weakens our ability to ensure that patients get important information about the CPR directive and that it is executed properly. **As a facility authorized to receive CPR directives, please take the responsibility to educate the individuals receiving the forms about CPR directives and to make sure that individuals choosing to execute a CPR directive get it signed by their physician.**

An information packet that will provide more details about the use of the CPR Directives is available by contacting the Colorado Medical Society, PO Box 17550, Denver, CO 80217-0550. The cost is \$3.50 and must be prepaid.

## AMA Health System Reform Efforts Continue

The American Medical Association has reaffirmed its support for universal coverage and access to health care services in recent statements. Lonnie R. Bristow, MD, Chair of the Board of Trustees, said the Association favored individual patient choice of insurance options rather than employer financed health care.

"The AMA, which endorses and promotes the health IRA as one of

the best means for assuring patients' freedom of choice in health insurance, endorses legislation to create Health Care Savings Accounts." said Dr. Bristow, "The AMA will continue to identify any further means through which universal coverage and access can be achieved."

Meanwhile, John E. Patchett, JD, Director of the AMA's Department of State Legislation invited Colorado Governor Roy Romer to participate in the 20th Annual State Health Legislation Meeting. Mr. Patchett said to the Governor, "Your participation in this session will provide the opportunity for you to present the perspective of the nation's governors." The Governor was invited to speak on state health system reform and how those efforts might fit into a federal health system reform plan.

## Air Quality Hearing

The next Air Quality Control Commission public hearing will be January 20, 1994 in the Sabin Conference Room of the Colorado Department of Health, 4300 Cherry Creek Drive South, Denver. Public testimony will be taken on the following items:

- 9:30 a.m. Amendments to Regulation No. 7 - volatile organic compounds
- 10:30 a.m. Revisions to Regulation No. 11 - Motor Vehicle Emissions
- 11:45 a.m. Regulation No. 15 - Control of Emission of Ozone Depleting Compounds
- 1:00 p.m. Proposed revisions to Regulation No. 3, Air Contaminant Commission Notices

To obtain copies of the proposed amendments, call the Air Quality Control Commission at 692-3278.





### Rheumatologist Honored

Herbert Kaplan, M.D., past Chairman of the Arthritis Foundation, Rocky Mountain Chapter and a rheumatologist with the Denver Arthritis Clinic, is the new President of the American College of Rheumatology. Dr. Kaplan has been a Colorado Medical Society member for the past twenty-eight years. In his newly appointed position, Dr. Kaplan will lead and represent over four thousand rheumatologists across the country as they meet to discuss their scientific breakthroughs in arthritis research, looking to find the cause and treatments for the over 100 forms of arthritis.

### Subacute Care Group Elects Colorado Physician



New Colorado Medical Society member, Gary W. Jay, M.D., executive medical director of the Headache and Neurological Rehabilitation Institute of Colorado, in Northglenn, Colorado, was recently named Vice President/Education for the American Subacute Care Association.

Dr. Jay, who also serves as Medical Director, Brain Injury, Headache and Pain Services, at Continental Medical Systems' Rocky Mountain Rehabilitation Institute, is an authority on brain injury and pain, will also chair ASCA's educa-

tion and conference program committees. Dr. Jay is a Diplomate of the American Academy of Pain Management and is certified by the American Society of NeuroRehabilitation.

### Regional HIV Conference

The Ninth Annual Rocky Mountain Regional Conference on HIV Disease will be Held February 4 - 5, 1994 at the Red Lion Hotel, 3203 Quebec St. in Denver. Some of the items on the conference agenda include: Viral and Immunological Factors Influencing Long Term Survival with HIV Infection, Clinical Update and Management of HIV Infection, Prevention of HIV in Adolescents and Women and AIDS: The Clinical Picture. Additionally, fifteen 90-minute workshops covering a wide range of topics will be offered during the conference.

Continuing education credits will be available for physicians, nurses, drug treatment counselors (ADAD certification) and health educators (CHES). The registration deadline is January 22, 1994. The fee is \$150.00. Registrations should be mailed to: The Colorado AIDS Project, Attention: AIDS Conference, P.O. Box 18529, Denver, CO 80218. Checks need to be made payable to: Colorado AIDS Project.

All net proceeds will benefit the Colorado AIDS Project, a nonprofit organization providing services and educational programs to those directly affected by HIV infection.

For further information, contact Terry Stewart at (303)837-0166 or

Peter Ralin at (303)436-7186.

### More HIV Info

A national HIV telephone consultation line, called Warmline, has been established, according to a report in the AMA's publication, "This Week".

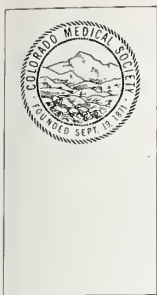
The service, for health care providers only, offers case consultation, drug information, literature searches, information on infection control, and referrals. It operates Monday through Friday, 7:30 a.m. to 5 p.m. (PST). Voice messages can be left at all hours.

This service is funded by the Health Resources Administration and the American Academy of Family Physicians and is offered by the Community Provider AIDS Training Project of the Western AIDS Education and Training Centers of the AIDS ETC program.

Warmline's number is (800) 933-3213.

### Edelman Resigns from Rose

Joel Edelman, known as a tireless volunteer and the guiding administrative force for Rose Medical Center for nearly 15 years will resign in March. He will be succeeded by Jeffrey Dorsey, current EVP and Administrator. Mr. Edelman said he will continue with Rose Foundation, "The role of philanthropy in supporting necessary community health projects and medical research is becoming increasingly critical, as funds traditionally derived from hospital operations continue to shrink under health care reform."



## HEALTH DEPARTMENT

### Additional Changes in Immunization Requirements

The August 1991 issue of *Colorado Medicine* contained an article outlining changes to the school entry immunization requirements which were approved by The Colorado Board of Health in May of 1991.

In November 1991 The Board of Health approved further changes to include requirements for mumps and rubella doses for 7th graders and college freshmen. Additionally, Senate Bill 122, which became law in February of 1992, set forth exclusions to the rule for certain types of nontraditional colleges and universities.

The original article appears below with additions in bold.

#### School/Child Care/ College Affected

In the rules, "school" is defined as a public, private or parochial nursery school, day care center, child care facility, family care home, headstart program, kindergarten, elementary or secondary school through grade 12, or college or university. **"School" does not include college or university courses of study which are offered off-campus, or are offered to nontraditional adult students, as defined by the governing board of the institution, or are offered at colleges or universities which do not have residence hall facilities.**

#### Effective July 1, 1991:

- I. Haemophilus influenzae type b (Hib) vaccine: The minimum number of doses required by age group is:

0 for children < 2 months  
1 for children 2-3 months  
2 for children 4-14 months  
1 for children 15 months-4 years  
0 for children  $\geq 5$  years

- II. A disease history for measles, mumps or rubella is not acceptable for certification; however, written evidence of a laboratory test showing immunity is acceptable.

#### Effective July 1, 1992

- I. 7th graders and college freshmen who were born since January 1, 1957 must have had two measles doses, **two mumps doses and two rubella doses; if the student received a second measles dose prior to July 1, 1992, the second rubella and mumps dose are not required.** The measles, mumps, and rubella doses must have been administered on or after the first birthday, and at least one month apart. By July 1, 1995 all college students born since January 1, 1957 must comply. By July 1, 1997 all students in grades 7-12 must comply.
- II. One dose of MMR (measles, mumps and rubella vaccine) must have been administered at age 15 months or older to be acceptable for certification for students who enroll of the first time in a nursery school, day care center, child care facility, family care home or school grade K-12.

For further information contact the Colorado Department of Health's Immunization program at (303) 331-8323.

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## RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor



Harry the Hopper

Well, Whadaya know? More likely, whodaya know? Going through my files a few weeks ago I found a copy of the September, 1958 issue of *"The Hopper Herald"* from Presbyterian Hospital in Denver. In this newsletter which was, I believe, mimeographed, I found pictures of the 1959-1960 House Staff of Presbyterian Hospital. Among them were these residents and interns. A few of you out there (at least five) will recognize these people right away. Most of the rest of you will take a little while before the names come to you. They are



identified at the bottom of this page.

I guess I always kept this file of newsletters around because I was fascinated with the name and the accompanying artwork.



The *"Hopper Herald"* actually was around a lot of years, and I believe it continued until about 1979 or '80. When I first saw it, I thought it was probably named the *"Hopper Herald"* because someone said "Hey, I know this guy who can draw a really great grasshopper. Why don't we start a newsletter so we can use the art?" That is not the case here.



The grasshopper got into the act in this newsletter because Presbyterian Hospital was built on what was called "Grasshopper Hill" at 1835 Williams Street in

1921. The original building later became the Nurse's residence. There was a School of Nursing at Presbyterian for many years.

The "Hill" has undergone a lot of changes since then. CMS was even headquartered on the hill at 18th and Williams, then at 19th and Gilpin.

There were a dozen or so photos in that "Herald" but these few were easily identifiable as physicians in Denver practice today.



While digging in the hospital records I was reminded that St. Joseph's Hospital, one of Denver's first, was built at 22nd and Blake Streets, which is at the right field corner of Coors Stadium. St. Luke's started out at 18th and Federal Boulevard, just west of Mile High Stadium.



Clockwise from the top left, John Crow, Jr., Brian James, Charles Daffoe, Richard Harvey, Robert Sawyer.



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January, 1994

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one... but how will we pay for it?

This Issue:

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- Balkanization Revisited by Wm. Carl Bailey, MD..... Page 55
- Health Reform Myths and Facts by Frederick A. Lewis, Jr., MD ..... Page 59
- New Members of the Board of Directors and Council on Legislation ..... Pages 58 & 61

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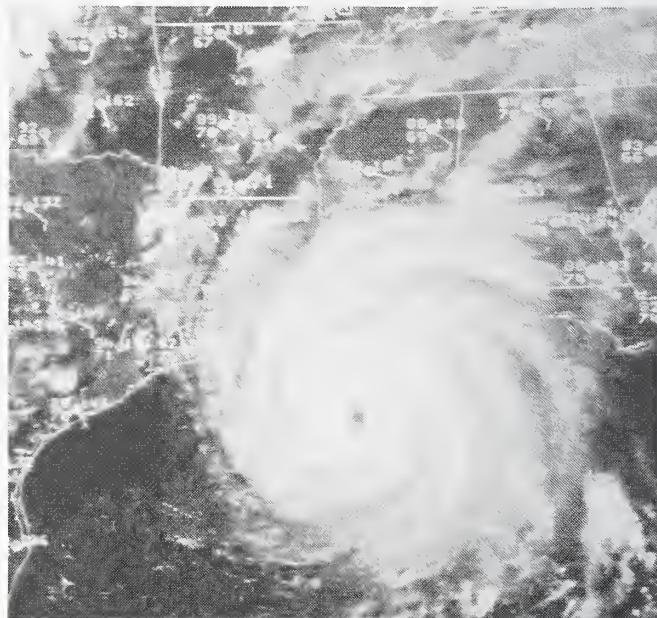


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# COLORADO MEDICINE

February, 1994

Volume 91, Number 2



## Cover Story

President Clinton promised many things in his State of the Union Speech January 25. How many of them can he deliver? See page 66 and other articles on health reform.



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## In The Palm of Your Hand

For some time now the emergence of new hand-held computerlike devices has been promising to change the way we do business. Everything from very small DOS-based PC's, such as those produced by Hewlett-Packard, to the Sharp *Wizard* series of "personal organizers" and their imitations, already offer users practical alternatives to daily planners, appointment books and note pads.

But until recently these "personal digital assistants", or PDA's as they have been dubbed, have offered limited, though sometimes useful, applications. We are now in the midst of a transition which many believe heralds the coming of age of the palm-top PDA's, a most recent example of which is the *Newton* product line from Apple Computer.

What differentiates the *Newton* devices from their predecessors in the hand-held world is their approach to the user interface. Using a pen-like tool called a stylus, users simply write notes which the *Newton* can translate into text. You can even exchange data between other *Newtons* using an invisible infrared beam, eliminating cumbersome cables and connectors. And its built-in "intelligence" actually prompts and helps you in making phone calls, faxing, sending electronic mail, printing, scheduling appointments and completing to do lists. And, astonishingly, it even learns your own personal quirks, habits and handwriting the more you use it.

But besides the way it's used, what really differentiates the *Newton* from the other, "simple" electronic personal organizers is its ability to take advantage of applications

specifically written for it, making it a little closer to the computer than the electronic organizer.

In fact, there now exists a practical (and fascinating) application for *Newton* called *Hippocrates*, specifically designed for physicians and health care professionals. Developed by HealthCare Communications, Inc., *Hippocrates* can communicate not only with other *Newton* devices, but also Macintosh, DOS and Windows systems. In fact, it will function with any system that transfers standard ASCII text formats (i.e. practically everybody). This flexibility gives the *Hippocrates*-equipped *Newton* the practical ability to retrieve data from users on the fly (e.g. during hospital rounds) and upload it directly into their office computer system, eliminating the need for duplicate data entry.

Specific tasks this new technology is assisting physicians with include patient scheduling, prescriptions, encounter tracking (yes, it can transfer billing data into your office system), charting information (including medical notes and drawings) and it even contains a personal pager as an option. It is capable of emulating office forms and notations, eliminating the need for paper. Users simply fill in the blanks using the stylus, and those entries are automatically converted to text. *Hippocrates* intends to replace many of the paper forms typically in use in hospitals, nursing homes, medical offices and home health care environments.

Even (especially?) those not familiar with traditional computer systems can get quickly acquainted with the *Newton-Hippocrates* system because of its intuitive user interface,

which relies more on on-screen buttons, icons and simple prompts than it does traditional keyboard data entry. It delivers a much more direct, "hands-on" look and feel.

An example of the increasingly "open" computer world we live in, *Hippocrates* takes full advantage of the *Newton*'s communications technology, permitting the faxing of prescriptions directly to a pharmacy (which requires an optional compact fax modem).

All this functionality from a less-than-one-pound device you can tuck into your coat pocket.

Of course, you will need to evaluate how such a device will interface not only with your current system, but also with your daily habits. It will probably take some imagination to take full advantage of all that *Newton* technology has to offer. As with any such revolutionary advances, your flexibility may be every bit as important as *Newton*'s.

And you will have to coordinate each function you plan to integrate into your current office system with your existing computer software and hardware vendors. Uploading and downloading data is still not an automatic capability. It has to be carefully set up in advance. Capability does not automatically equal feasibility.

But the upside advantages such a device offers, and its ramifications for increasing accuracy and productivity, may well warrant an investigation. After all, even as you read this, people are actually using *Newton* devices. And they like them.

For more information or an evaluation of *Newton* technology in your environment, contact Paul Carter, HealthCare Marketing, (303) 696-7552



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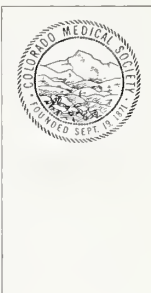
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## Balkanization Revisited

**Introduction** *In my first letter as the President of Colorado Medical Society (Colorado Medicine Vol. 90, No. 10: 339-343) I wrote of the threatened balkanization of the profession, urging Colorado physicians to 'take the high ground and preserve and hopefully improve the health and the social fabric of the society in which we live. If now we fail to act in concert and with determination, the loss may be incalculable.'*

*In four short months the profession has changed dramatically, and I cannot stress enough the increased need for physicians to close ranks to protect the profession and the very art and science of medicine.*

**Holism [f. Gr.]** *The tendency in nature to produce wholes from the ordered grouping of units.*

Do you remember how it was, when we were all medical students? We were intent upon knowing as much as we could about the human being — "the skin and its contents", we joked. We felt a camaraderie, sharing common experiences, and we just wanted to be doctors. Then our careers began to diverge as residency training and specialization ensued. We joined specialty societies, and communications with each other became a little less good. As time passed, more and more science and technology required mastery, and we became more and more absorbed, each in his own world. We identified ourselves not simply as "doctor" but by specialty. Our specialty societies became the social organization or "tribe" which gave us our identity, and tended also to separate use from other "tribes".

Specialty societies themselves have changed over time. For example, a friend of mine who has recently had occasion to read the minutes from his specialty organization's early day meetings, recounted the descriptions of those meetings as they were held at different doctors' homes in Denver. One could, with a nostalgia for a time none of us can know, almost

smell the aroma of the cigars, the bouquet of the brandy, and hear the high spirited banter of these physicians as they exchanged case anecdotes and discussed the latest articles relating to their specialty. It was a much simpler, and probably happier time. Now these little groups have coalesced to become powerful organizations. Not as much fun, but widely used to promote the political and economic interests of their memberships, with varying degrees of success. Unfortunately, the interests pursued may at times conflict with those of other groups.

Now, to add to the forces of fragmentation, come a plethora of social, political, and economic forces. Society has decided that medical care costs too much, and the expense is escalating at a ruinous rate. It is consuming national resources at the expense of infrastructure such as education and community services. Too many people are without adequate medical and preventive health services. There is a maldistribution of physicians with too many specialists, and not enough primary care physicians, and too many doctors in towns and suburbs, and not enough in inner cities and rural areas. There is a presumed absolute overcapacity of physicians. While there is a demand to reduce costs, there is an increasing demand



*We are all doctors together, and together we can accomplish what is best for our patients, and preserve the best of what most of us still feel is a noble profession.*

## ***Holism is the natural key to survival.***

for high technology. As malpractice litigation against physicians is again on the rise, the anti-establishmentarianism of the public results in an increased demand for practitioners of less skill and education to take over more of the function of physicians. A recent poll in California is purported to show that 80% of the people surveyed want alternative health care to be paid for under health care "reform". To add to this complex of problems, we now confront the specter of Big Business and Big Government, and it is very difficult to tell which is the greater evil. Rationing of health care and incursions upon professional autonomy appear to be inevitable. It is no wonder that physicians are increasingly driven apart as they attempt in their own microcosm to deal with these macrocosmic issues.

In the *AM News* of January 10, 1994, appeared an article by Nina Sandlin dealing with the struggle of physicians to adjust to this rapidly changing environment. She quotes John-Henry Pfifferling, PhD., who set up the Center for Professional Well-Being in Durham, NC to help physicians cope with burnout and stress-related disorders. Dr. Pfifferling, who trained as a cultural anthropologist did his dissertation on resistance to change among doctors in New England. In his comments (to paraphrase) he notes that in tribal societies confronted by rapid modernization, there often is tremendous friction between elders and juniors, with less concern for transmission of traditions, support, rituals, and cultural values to the younger (doctors) who will carry on. Such a group at the crossroads can coalesce

and be "reborn in the new world", distilling and preserving what is important, "or it can segment, divide, fission, and break apart - then you hope there are some new entities that grow out of it". Dr. Pfifferling says that "the fission scenario is grim for the profession/tribe" for that is when you get "endocannibalistic behavior - you eat your own, backbite, blame and look for victims in your own society". He believes that things are shifting in this direction: where once divisions existed between physicians and administrators, or physicians and insurers, now they are between physicians.

Whether or not one agrees with Dr. Pfifferling, it is clear that both as individuals and collectively we are being subjected to enormous stress. Even as we debate what health care reform should look like, managed care has arrived. *AM News* reports that in some parts of the country less than 10% of the populace is insured under fee-for-service. Where there are now 250 physicians per 100,000 population, under managed care it is projected that only 125 physicians per 100,000 will be needed in the future. Some physicians have reported losing 10 to 30% of their practices overnight. Again, as we discuss scope of practice for non-physician providers, the recruiting organizations report that the supply cannot meet the demand. Physicians and provider groups are competing to hire physician extenders as a less expensive substitute for physicians.

The 1994 session of the Colorado Legislature is under way. Some of you will be called upon to testify in hearings. Hopefully, all of you and your spouses will familiarize your-

selves with the issues and make your feelings known to your personal representatives in the Senate and House. There has never been a more important time for the house of medicine to be in order. The general medical society and the specialty societies **must** work together. Members of the specialty societies must encourage their members to also join the Colorado Medical Society and the AMA. It is clear that one large organization speaking for all physicians can accomplish far more than a relatively smaller group seeking only its own narrow interests. By efforts such as the Legislative Coalition, we can achieve much.

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## EXECUTIVE DIRECTOR'S UPDATE



*Sandra L. Maloney  
Executive Director  
Colorado Medical Society*

Colorado Medical Society is, as you know, going through some major changes, working to adapt to the ever-changing needs of the professional members. In so doing, it was decided before 1993 ended that CMS should go to an as-needed, contract form of lobbying service. There were necessary changes in staffing and budget.

As of November, our Government Relations Division was trimmed to two persons and we began the process of interviewing for lobbying services.

Twenty-two separate persons or business entities submitted proposals. Of these, ten were selected for interview or consideration. This group was then reduced to three finalists, each of whom was interviewed by CMS officers and Dr. Fred Lewis, chairman of the Legislative Council. A final selection was made in January and the Colorado Legislative Services, Inc., was selected and have begun to represent CMS with the opening of the session January 12th.

Principals in this organization are Jerald B. Johnson, Bonnie J. Geiger, Cathy Walsh and James J. Cole. All four of these people bring many years of professional lobbying, from both the public and the private perspectives. They work as a team, each having knowledge and experience in separate and distinct areas of legislative interests.

Colorado Legislative Services, Inc., is a 13 year old company and, as a result, has kept abreast of the issues critical to medical practice during the major shifts of public attitudes toward medicine and health

care. This experience will serve CMS well.

CMS leadership felt the lobbying efforts should be more in keeping with the interests expressed at the July leadership meeting in Fort Collins. It was thought that Colorado Legislative Services could better adapt to those needs because of the multiple lobbyist approach. Four professionals with diverse knowledge and background stands CMS in good stead to keep pace and deal with the changing character of the legislature. **If nothing else**, we are increasing our lobbying exposure dramatically. As you can see, we have suddenly increased our lobbying resources by more than 100%, going from three persons on staff to seven lobbyists whenever we need to bring so powerful a focus to an issue.

I am confident that this new approach (contract service versus full-time employee) will serve the legislative needs well.

Yes. . . CMS IS changing, and we're honing skills, goals, objectives, operations and budget to fit the new times. There are several areas of reorganization within the CMS divisions, working to get the most out of every "person" hour, every day. I look forward to dealing with those other areas as we progress through the new year. If you have any questions about these or any changes in CMS, don't hesitate to call or write.

Remember, though, that I do not acknowledge anonymous letters.

**"Yes. . . .  
CMS IS changing..."**



# 1993-1994 Members of YOUR Board of Directors

*In January, 1993, we published a pictorial introduction to your CMS Board Members. Here are those who were not pictured or have joined the Board since then...*



**Wm. Carl Bailey, MD**, as President of the Colorado Medical Society, chairs the Board of Directors. Dr. Bailey has curtailed his Pediatric Surgery

practice to serve his time in the CMS office. He has been a member of the Colorado Medical Society for 35 years.

**David C. Martz, MD** is President-Elect for 1993-1994 and will take office as President in September, 1994. Dr. Martz is a Colorado Springs Internist who specializes in Hematology and Oncology and previously served as Vice-Speaker of the House of Delegates.



**Stephen G. Batuello, MD** was the representative for the Medical Student Component last time we published the Board of Directors, however, his picture

was not available. Since then we have obtained his picture and he has begun a residency in Surgery. He now represents the Resident Physician Section on the Board.

**Donald G. Eckhoff, MD** was also absent last time we took photos, but you see here that he is still representing Denver Medical Society on the Board. Dr. Eckhoff is an Orthopedic Surgeon and has been a member of the medical society for 16 years.



**Dr. David Knize** is a Plastic Surgeon who represents Arapahoe County on the Board. He received his Doctorate of Medicine from the University of Texas Southwest and lives and practices in Englewood.



**Dr. Robert L. Kruse** also represents Arapahoe County. He is an Orthopedic Surgeon from Englewood and received his Doctorate from Northwestern University School of

Medicine in Chicago before serving an internship in Minneapolis and his residency at the Mayo Clinic.

**John B. Muth, MD** is Director of the El Paso County Department of Health when he is not representing that county on the CMS Board of Directors. Dr. Muth specializes in Public Health and OB & Gynecology. He has been a member of the medical society for 12 years.



**Dr. Robert Nathan** also represents El Paso County during the time he can spare from his Allergy, Immunology and Asthma practice in Colorado Springs. Dr.

Nathan got his medical training from the University of Miami School of Medicine and has been a CMS member for 16 years.

**L. Karl Roller, MD** specializes in Radiology and Nuclear Medicine in Cañon City, Colorado. He represents the SE Rural Medical Society and has been a member of the CMS for 30 years. He was educated at the University of Heidelberg, Germany.



He was also not pictured in the last introduction of Board members.

**Dr. Elaine Scholes** is one of Denver's representatives on the Board of Directors. Dr. Scholes is a Pediatrician who received her medical degree from the University of Kentucky and served her internship and residency at the Children's Medical Center in Texas. She has been a Colorado Medical Society member for 11 years.



**Susan A. Sherman, MD** was a non-pictured member of the Board last time. She still represents Aurora-Adams County where she

resides and practices Internal Medicine, specializing in Endocrinology & Metabolism and Diabetes. Dr. Sherman was educated at the University of North Carolina and has belonged to the medical society since 1977.

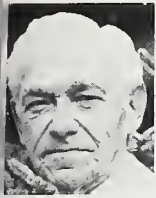
**Dr. Joseph A. Tyburczy** is a General Surgeon from Greeley who represents the Weld County Medical Society on the Board. Dr. Tyburczy did his internship right here in Colorado at Denver's Presbyterian Medical Center and his residency at St. Joseph Hospital. He has belonged to the CMS for 15 years.



**Theresa A. Scholz** is a student at the University of Colorado School of Medicine in Denver. She represents the Medical Student Component

on the Board of Directors and has been a member of the Colorado Medical Society for three years.

Photos by Gil Maestas, II (Drs. Bailey, Batuello, Eckhoff, Knize, Kruse, Scholes and Sherman) and Mike Thompson (Dr. Martz).



Frederick A. Lewis, Jr., MD  
Chair, Council on Legislation  
Colorado Medical Society

*Editor's note: This article was published in the editorial section of the Denver Post, January 21, 1994, in response to an opinion piece by Colorado State Representative Daphne Greenwood published on Saturday, January 1, 1994.*

**S**tate Representative Daphne Greenwood's op-ed piece on health care reform (HCR) in the January 1, 1994 edition of the Denver Post literally cries out for a rebuttal.

Unfortunately for public understanding of this complicated issue, a "shorthand" language has been developed by those interested in HCR. This interferes with clear communication to the non-involved and makes the subject appear more complicated than it really is. However, in the interests of brevity, I will use the same conventions and same style as Representative Greenwood.

**Myth 1.** *There is a tremendous amount of organized opposition to HCR within participating health care organizations in this country.*

**Fact:** Almost everyone involved is in favor of health care reform. The problem is a lack of unanimity of opinion about implementation. (The devil is in the details.) The American Medical Association has a plan called "Health Access America". The Colorado Medical Society has a five-page resolution that outlines our position on HCR and includes support for a number of basic principles, including "universal coverage". The

American Hospital Association, every insurance group, and every organized business group has its own plan. There are currently at least six HCR bills in Congress. At least four bills will be presented to the Colorado legislature. It does not enlighten the debate by pretending that everyone is opposed to change.

**Myth 2.** *Universal coverage will be more expensive than our current system.*

**Fact:** Every independent actuary and consultant who has looked at the problem has agreed that it will cost more money to insure more people. This is a fact that the majority of the people have no difficulty in understanding. "Cost shifting" is a real problem, opposed in principle by everyone involved. However, changing the reimbursement system is not likely to keep people from seeking health care in the emergency room.

**Myth 3.** *Bureaucratic intervention is likely to have an adverse impact on the delivery of health care.*

**Fact:** A study of deliberate governmental interventions in the health care delivery system over the past forty years (by both Democratic and Republican administrations) reveals a long history of unexpected adverse results, continual increase in bureaucratic rules and regulations, needless expenditures of large sums of public funds on multiple short term,

*"Every independent actuary and consultant who has looked at the problem has agreed that it will cost more money to insure more people."*



***"[I]f any physician agrees to contract with any individual to provide health care outside the system, this act is punishable by significant fine and/or jail."***

ineffective programs, increases (not reductions) in health care costs, and expenditures which vastly exceeded estimates made by bureaucrats. This should not be attributed to malevolence or ignorance — but simply to the fact that large social systems frequently do not respond to change in the predicted fashion.

**Myth 4.** *The most expensive care comes in the last month of life. We could save money by not investing money in health care during this period. Additionally, preventive medicine will save significant amounts of money.*

**Fact:** There is no disputing the first premise. However, until medicine develops a system that will consistently predict the last month of life, the suggested solution is not very practical. In terms of prevention, sooner or later everyone becomes sick and dies. The longer people live, the higher the national health care bill is likely to be. This is one of the conventional reasons given for the steady increase in the cost of national health care.

**Myth 5.** *There is "a paperwork crises".*

**Fact:** Organized Medicine has long supported simplification of paperwork. All physicians would cheerfully support legislation implementing this concept.

**Myth 6.** *Canadians come to the U.S. because of long waits in Canada.*

**Fact:** There can be no debate as to whether or not U.S. citizens have more rapid access to health care than Canadians. They do. One can argue as to whether or not this is desirable

but not whether or not it is a fact.

**Myth 7.** *Universal health coverage will mean a massive increase in taxes.*

**Fact:** HCR will cost more money. There are a number of alternative financing possibilities under intense scrutiny and debate at the present time. One of the alternatives, deficit financing, would not immediately increase taxes.

**Myth 8.** *HCR would result in massive unemployment.*

**Fact:** This is one of those outcomes that is unpredictable and probably not relevant to HCR.

**Myth 9.** *Introducing universal health care is sure to result in better health for the U.S. population.*

**Fact:** This is certainly a myth. I would agree completely with Rep. Greenwood that poverty, public health measures, the welfare system, seat belt legislation, violence, gun control, alcohol and tobacco use, etc., all have a serious impact on health. It is for this reason that public health statistics (longevity, infant death, etc.) have so little relationship to the quality of individual health care.

**Myth 10.** *Clinton's Health Security Act will guarantee continuation of free choice of physician, perpetuation of the patient-physician relationship, ensure the continuation of "fee for service" medicine, and provide for significant tort reform.*

**Fact:** Despite the fact that all of these allegations have been made publicly by the current administration, a careful reading of the legislative

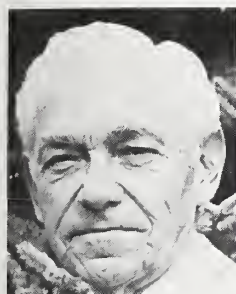
language of the proposed bill reveals that none of this is likely to be true. In addition, if any physician agrees to contract with any individual to provide health care outside the system, this act is punishable by significant fine and/or jail.

**Myth 11.** *HCR is being pushed because the current health care system is inadequate.*

**Fact:** Our health care system is the best in the world. There is little disagreement about the fact that it is also too expensive. This is the real impetus behind HCR and this fact should not be obscured by rhetoric. At least one of our societal goals in HCR should be to preserve quality. Physicians, by virtue of their education and training, are probably the only group in our society which possesses the expertise necessary to suggest ways of reforming the system so that quality is preserved while costs are cut. The major difficulty has been that physicians have not been given the responsibility and authority necessary to systematically address this problem. In fact, physicians were excluded from Mrs. Clinton's health care reform planning group. Most physicians would agree that, currently, there are perverse incentives in the system that could and should be corrected. The Colorado Medical Society does not oppose Health System Reform. We are very concerned about the potential adverse impact of wholesale changes on the health of our patients and the economy of our country. As we should have learned from the past 30 years, there is no "going back". Once changes are made, they can not be reversed. The only option, at that point, is to make more changes which may or may not decrease the damage done by the first set of changes.

# 1994 Council on Legislation

Here are some of the people who represent you in formulating positions on health care legislation in Colorado. Look for the rest in the March issue of *Colorado Medicine*. If you want to have input to the process or just get more information you may call the CMS Government Relations office at (303) 779-5455 or 1-800-654-5653, or contact one of the members of the Council.



The Council is chaired by **Frederick A. Lewis, Jr., MD**. Dr. Lewis is a native of Tuscaloosa, Alabama. He is a Diplomat of the American

Board of Psychiatry and Neurology and a Life Fellow of the American Psychiatric Association. Dr. Lewis has been President of the Colorado Medical Society, the Denver Medical Society, the Colorado Psychiatric Society and the Colorado Foundation for Medical Care. He and his wife Jeanne have five children.

**Harrison G. "Corky" Butler, III, MD** is also a past President of the Colorado Medical Society and of La Plata Medical Society in his home town of Durango.



Dr. Butler practices Peripheral Vascular Surgery at Mercy Medical Center in Durango where he is Director of the Non-invasive Vascular Laboratory. Dr. Butler served a previous term on the Council on Legislation and is a member of the Board of Directors of the Colorado Physicians Health Project. In addition to medicine, Dr. Butler enjoys flying his own aircraft. He and his wife Judy live in Durango and have two children.



**Sally A. Coates, MD** followed a BS from MIT with medical training at Boston University. She is board certified in Emergency Medicine, which she practices full time at Littleton Hospital. She is also a partner in Emergency Physicians at Porter Hospital and at one time split

her time between three hospitals to get more time with her adopted child. Dr. Coates and her husband Asa (who is also a physician) have one son and live in Englewood, Colorado.

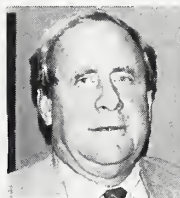


**Guillermo H. "Willy" Davila, MD** was born in Minneapolis, Minnesota and received his bachelor's degree in El Paso, Texas before moving to La Paz, Bolivia for two years of

study at the medical school there. He returned to Texas to finish his education and did a residency at the University of Colorado in Obstetrics and Gynecology. He is currently the Director of the Colorado Gynecology and Continence Center at P/SL in Denver. He has published in several media.

**Ben Galloway, MD**

is a native of Rockford, Illinois. He has been interested in Colorado politics for some time, having run for 5th District representative in 1974. He has served several Governors as part of the Medical Advisory Committee and has served on the Colorado Medical Society Legislative Council since 1980. He is certified in Anatomic, Clinical and Forensic Pathology.



**Stewart L. Greisman, DO** received his medical education from the College of Osteopathic Medicine and Surgery on Des Moines, Iowa, but did his residency at Denver General Hospital in Emergency Medicine. Dr. Greisman is a Diplomat of the American Board of Emergency

Medicine and a Fellow of the American College of Emergency Physicians. He serves on the Board of Copic Insurance Company, is a member of the Colorado State Board of Medical Examiners and is the Chairman of the Emergency Medical Care Physician Advisor Committee of the Colorado Medical Society. He is married to Priscilla and has two children.



**Mary Jo Jacobs, MD** was graduated cum laude with a Bachelor of Arts in Chemistry from Park College in Missouri before receiving her medical degree from the

Medical College of Pennsylvania. She carried out a private practice in Family Medicine and Occupational Health until 1988 when she returned to school and received two Master's degrees, one in Public Health and one in Public Policy. She presently practices managed care, emergency medicine and urgent care and chairs the National Health Care Reform efforts of the Colorado Medical Society.

**Sherri J. Laubach, MD**

is a Family Practitioner in Lakewood, Colorado. She has been active in organized medicine in Colorado since 1981, when she was first elected to membership in Clear Creek Valley Medical Society. She served on the CMS Maternal and Child Health Committee and the Health Care Reform Committee and chaired the Council on Community Health Issues from 1990-1993. Dr. Laubach received her medical degree from Jefferson Medical College and did her residency at Sacred Heart Hospital in Allentown, Pennsylvania.







# Rules and Regs Governing Direct Entry (Lay) Midwifery

In 1993, the Colorado legislature passed a bill which allows lay midwives to practice in the state. The bill requires lay midwives to register with the Board of Nursing. The Board of Nursing was the state agency charged with developing the rules and regs for the practice of lay midwifery as well as the associated complaint process and form.

A summary of the rules and regs will be presented here. If you wish copies of the complete rules and/or the complaint form, please contact the Board of Nursing at (303)894-3437.

## Registration

Lay midwife registration will consist of a passing an exam and paying an application fee. Those who will be eligible to take the exam must: be 18 years of age or older, have CPR certification, submit proof of a high school diploma or equivalent, be verified graduates from a state-approved lay midwifery program or have education which meets or exceeds the requirements for state midwifery program approval.

(The first exam was given on December 14, 1993. Registration of those who passed the exam was complete January 1, 1994.)

The rules state that lay midwives must renew their registration every year. Each applicant for renewal will be required to submit the following: the number of women to whom care was provided during the last year; the number of deliveries performed; Apgar scores of the infants; the number of prenatal transfers; the number of transfers during labor and delivery and the immediate postpar-

tum period; the number of perinatal and maternal deaths; the number of women who were referred for maternity care to a licensed health care provider at the time of the initial visit.

## Standards of Practice

The rules and regs prohibit lay midwives from: 1) performing any operative or surgical procedure; 2) utilizing any instruments, other than hemostats to clamp the cord, or mechanical means of delivery; 3) performing versions; and, 4) administering any medications except for eye prophylaxis of the newborn.

The rules additionally direct lay midwives not to accept as patients women whose medical history shows any of the following:

- A. Diabetes mellitus or gestational diabetes;
- B. Hypertensive disease (BP greater than 140/90 at rest);
- C. Pulmonary disease which interferes with activities of daily living;
- D. Cardiac disease which interferes with any activities of daily living;
- E. Blood dyscrasia, for example sickle cell anemia;
- F. Seizures controlled by medication if the mother has seized within the last year;
- G. Hepatitis B;
- H. HIV positive or AIDS;
- I. Taking psychotropic medications;
- J. Current substance abuse (drugs or alcohol);
- K. Thrombophlebitis or pulmonary embolism;
- L. Rh sensitization (positive antibody titre);
- M. History of previous cesarean

section or other uterine surgery without an intervening normal pregnancy with vaginal delivery unless the emergency plan reflects the ability to obtain medical consultation and an emergency cesarean section within 30 minutes;

- N. History of an incompetent cervix;
- O. History of hemorrhage after a previous delivery with a recurring etiology, for example, placenta accreta; or
- P. History of infants who were SGA, LGA, premature, stillborn or neonatal deaths associated with maternal health or genetic anomaly without an intervening normal pregnancy

## Frequency of Visits

Requirements for frequency of visits, care which must occur at each prenatal visit and lab tests which must be performed are also outlined in the regs.

## Required Referral to Licensed Health Care Providers

Lay midwives are required to refer mothers for evaluation to a qualified licensed health care provider and not continue as the care provider when the following conditions are noted: 1.) multiple gestation; 2.) presentation other than vertex at the onset of labor.

The regs state that when the following conditions are present, lay midwives must not continue as the primary care provider and must refer mothers to a qualified licensed health care provider until such time as the qualified licensed care

provider has determined that the pregnant woman is not exhibiting signs or symptoms of increased risk of medical, obstetric or neonatal complications or problems during the completion of her pregnancy, labor, delivery, or the postpartum period; or, that there is no increased risk that her child may develop complications or problems during the first 6 weeks of life:

1. Urine glucose of 2+ or greater on two sequential visits or if other signs or symptoms of gestational diabetes occur with the urine glucose;
2. Hyperemesis beyond the 24th week of gestation;
3. Hypertension;
4. Signs and symptoms of preeclampsia including persistent edema occurring with increased blood pressure or proteinuria, increased reflexes, persistent headaches, epigastric pain or, visual disturbances;
5. Seizures;
6. Vaginal bleeding after 20 weeks;
7. Signs and symptoms of urinary infections or sexually transmitted disease;
8. Oral temperature in excess of 101.5 degrees Fahrenheit for more than 24 hours accompanied by other symptoms of clinically significant infection, or which does not resolve within 72 hours;
9. Laboratory results indicating need for medical treatment, for example, a positive culture;
10. Anemia not responding to over the counter iron therapy as measured by Hemoglobin below 11 grams or Hematocrit below 34% at term;
11. Polyhydramnios or oligohydramnios;
12. Suspected fetal demise - lack of fetal movement, inability to auscultate fetal heart tones;
13. Decreased fetal movements;
14. Gestation longer than 42 weeks;
15. Rupture of membranes for longer than 12 hours without labor;
16. Premature labor - less than 37 weeks gestation;
17. Active herpes;
18. Intrauterine growth retardation;
19. Suspected abnormality of pelvis

## Informed Consent/ Mandatory Disclosure

The regulations stipulate that the lay midwife must provide the client with a mandatory disclosure form which contains a listing of the midwife's education; a statement indicating whether the midwife is covered under a policy of liability insurance for the practice of lay midwifery\*; a listing of any license, certificate, or registration in the health care field previously held by the lay midwife and revoked by any local, state, or national health care agency; and information on how and to whom to register a complaint. The lay midwife is also mandated to obtain informed consent on forms provided by the Director of Registrations. The consent form must include information on available alternatives to lay midwifery care and a statement informing the client that, in the event subsequent care is required resulting from the acts or omissions of the lay midwife, any physician, nurse, prehospital emergency personnel, and health care institution rendering such care shall be held only to a standard of gross negligence or willful and wanton conduct.

\*CRS 12-37-109 (3) states that "At such time as liability insurance becomes available at an affordable price, the direct-entry midwife shall be required to carry such insurance."

## Emergency Plan

Lay midwives must complete an emergency plan with each client. A copy of such plan shall be given to the client. The regs state that the time required for transportation to the nearest facility capable of providing appropriate treatment shall not exceed 30 minutes, unless the emergency plan includes an estimate of time for transportation for appropriate treatment of conditions which are specified in the regs.

## Immediate Consultation and Transport

Registered lay midwives are required to arrange for immediate consultation and transport according to the emergency plan when the

following conditions exist :

1. Bleeding other than capillary bleeding ("show") prior to delivery;
2. Signs of placental abruption including continuous lower abdominal pain and tenderness;
3. Prolapse of the cord;
4. Any meconium staining without reassuring fetal heart tones, meconium staining of 2+ or greater regardless of status of fetal heart tones;
5. Significant change in maternal vital signs;
6. Failure to progress in labor;
7. Fetal heart rate below 120 or above 160 between contractions;
8. Protein or glucose in the urine;
9. Seizures;
10. Atonic uterus;
11. Retained placental fragments;
12. Vaginal or cervical lacerations requiring repair;

## Newborn Care

The rules specify the care which the registered lay midwife must provide to the newborn as well as conditions for which the newborn must be transported.

## Record Keeping

The minimum information which the lay midwife must include in the patient's record is delineated.

## Criminal Penalties

According to Colorado Revised Statute 12-37-108, any person who practices or offers or attempts to practice lay midwifery without first complying with the registration and disclosure requirements commits a class 2 misdemeanor for the first offense. Any subsequent offense will be classified as a class 6 felony.

## Liability of Licensed Health Care Providers Who Administer Subsequent Care

No licensed physician, nurse, prehospital emergency medical personnel, or health care institution shall be liable for any act or omission resulting from the administration of services by a registered lay midwife. CRS 12-37-109(1)(a)



# 1994 Legislative Internship for Physicians

The Legislative Internship is a program for physicians which was implemented two years ago by Joseph Butterfield, MD. Dr. Butterfield saw a need for physicians to become comfortable and familiar with the Colorado Legislature. If doctors do not actively participate in the legislative process they will lose the ability to influence legislation from a medical standpoint.

Using his experience as a registered lobbyist, Dr. Butterfield offers a practical and concise approach in introducing Colorado physicians to state government.

The 1994 Legislative Internship for physicians consists of:

- an introduction to state government and the lobbying process with former congressman Ray Kogovsek.
- a day at the legislature.
- assignment of a bill to follow through the session.
- a monthly information session

with other interns and guest legislators, lobbyists, or legislative staff.

- periodic teleconferences with national health policy experts.
- a sine die wrap-up luncheon with a guest speaker.

The internship program is offered at no charge other than the cost of meals at the monthly sessions.

If you wish to register for the next session call Margaret at (303) 861-6509. Registration limited to ten - first come, first served.



Front (L-R) Phil Clodfelter, MD, Neil Kesselman, MD, Jerome Buckley, MD, David Herr, MD.

Back (L-R) L. Joseph Butterfield, MD, Kate Clark, MD, Bud Lashlee, MD, Jim Gilman, MD, former Colorado State Representative Charlie Brown, Wallace White, MD



## SPOTLIGHT ON LEGISLATORS

### Senate Committee on Health, Environment, Welfare & Institutions



Chairman,  
Sally Hopper (R)  
Golden, District 13



Michael C. "Mike"  
Bird (R) Colorado  
Springs, District 9



Lloyd A.  
"Casey" Casey  
(D), Northglenn  
District 23

Donald J.  
Mares (D),  
Denver,  
District 31



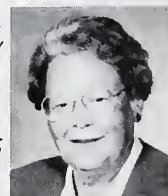
Richard F.  
"Dick"  
Mutzebaugh  
(R), Highlands  
Ranch,  
District 30



Paul M.  
Weissmann  
(D), Louisville,  
District 17



Dorothy S.  
"Dottie"  
Wham (R),  
Denver,  
District 35



# New Stamp Scores High for Denver Perinatologist



by Michael P. Thompson  
Assistant Managing Editor

"What's the one minute Apgar, Doctor?"

I remember a nurse asking that question as I got my first glimpse of the most beautiful baby girl in the world a few short years ago. The same question has probably echoed through more delivery rooms than you and I can count, including the ones many of us were born in.

That subtle and simple test, the Apgar score, includes items so obvious, one wonders at first why the questions even need to be asked. Yet the awareness raised by those questions has made both physicians and nurses pay more critical and immediate attention to the vulnerable newborn at a time when many conditions can still be mitigated.

That famous scoring system is only one of the reasons Joe Butterfield, MD has spent the past ten years lobbying for a U.S. Postage stamp honoring the famous anesthesiologist and perinatal researcher. In fact, Dr. Butterfield is the reason I now know the meaning of the nurse's question. He has kept the Colorado Medical Society and its members informed of the progress in his quest to see Dr. Apgar honored with a stamp.

The fulfillment of that quest will probably mean a life-style change for Dr. Butterfield. He recently told a reporter, "It became an obsession. I thought about it every waking moment."

Dr. Butterfield had met Dr. Apgar when she was in Denver for an exhibition about 40 years ago. "She was a very special lady," he said, "She was a legend in medicine."

Dr. Apgar was the 50th physician and the first woman to be board certified as an anesthesiologist. She became medical director of the March of Dimes out of her concern for babies born with injuries or genetic defects. She was known as a tireless but well received crusader for the cause of providing these children with a better life, from pushing rubella vaccine to educating mothers on the dangers of alcohol and drugs while pregnant.

Dr. Julius Richmond, former Surgeon General of the United States, said of Dr. Apgar that she has done more to improve the health of mothers, babies and unborn infants than anyone this century. Indeed, one physician said that each baby born in a modern hospital is seen first through the eyes of Virginia Apgar.

Dr. Butterfield has also had his share of praise for seeing the stamp project through to completion. Betty A. Lowe, MD, President of the American Academy of Pediatrics, wrote to him, "The stamp is not only a fitting tribute to Dr. Apgar, but it's also a testament to your extraordinary abilities....Your efforts serve as a reminder to us all that we can indeed make a difference, with hard work, persistence and a commitment to what we believe in."

The March of Dimes Office of Government Affairs in Washington noted his accomplishment in their national newsletter.

Look for the Virginia Apgar stamp at your Post Office in October as part of the Great Americans series. It will be a 20¢ stamp available in panes of 100.



**L. Joseph Butterfield, MD, Denver, Colo.,** is shown here wearing his 1992 Virginia Apgar Award for outstanding contributions to Perinatal Medicine.

*With the fulfillment of this quest, what direction will Dr. Butterfield's fascination with Virginia Apgar take next?*







## HEALTH SYSTEM REFORM (ALA CLINTON)



### **Welfare reform AND health care reform**

I know it will be difficult to tackle welfare reform in 1994 at the same time we tackle health care, but let me point out I think it is inevitable as well as imperative. It is estimated that one million people are on welfare today because it is the only way they can get health care for their children. Those who choose to leave welfare for jobs with out health benefits... and many entry-level jobs don't have health benefits - find themselves in the incredible position of paying taxes that help to pay for health care coverage for those who made the other choice to stay on welfare. No wonder people leave work to go back to welfare to get health care coverage. We've got to solve the health care problem to have real welfare reform.

So this year we will make history by reforming the health care system, and I would say to you, my fellow public servants, this is another issue where the people are way ahead of the politicians. That may not be popular with either party, but it happens to be the truth.

I know there are people her who say there's no health care crisis. Tell it to the 58 million Americans who have no health care coverage at all for some time each year. Tell it to the 81 million Americans with those preexisting conditions. Those folks are paying more or they can't get insurance at all, or they can't ever change their jobs because they or someone in their family has one of those preexisting conditions. Tell it to

the small businesses burdened by the skyrocketing cost of insurance. Most small business cover their employees and the pay on average of 35% more in premiums than big business or government. And tell it to the 76% of insured Americans, 3 out of 4 whose policies have lifetime limits. That means they can find themselves without any coverage at all just when they need it the most.

So if any of you believe that there's no crisis, you tell it to those people... because I can't.

From the day we began our health care initiative, it's been designed to strengthen what is good about our health care system: the world's best health care professionals, cutting edge research and wonderful research institutions, Medicare for older Americans. None of this should be put at risk, but we're paying more and more money for less and less care. Every year, fewer and fewer Americans even get to choose their doctors. Every year, doctors and nurses spend more time on paper work and less time on patients because of the absolute bureaucratic nightmare the present system has become. This system is riddled with inefficiency, with abuse and with fraud, and everybody knows it.

In today's health care system, insurance companies call the shots. They pick whom they cover... and how they cover them. They can cut off your benefits when you need your coverage the most.. They are in charge! What does it mean? It means every night millions of well insured Americans go to bed just an illness , an accident or a pink slip away from

(If you get the urge to call and comment on any of the Washington, D. C.-inspired health care plans in coming days, here is the "White House Comment Line" - (202) 456-1111)

*Editor: Excerpt from President William Clinton's State of the Union address, Tuesday, January 25, 1994. The President emphasized three major points in his talk, welfare reform, health care reform and reduction in crimes and violence by escalation in federal jobs programs. The President included something meliorating for every special interest listener; political, health care, industrial, laborer, small business. The excerpt is a fine example of "something for everyone". One observer called it a "very Republican speech".*

having no coverage or financial ruin. It means every morning millions of Americans go to work without any health insurance at all... something that workers in no other advanced country in the world do! It means that every year, more and more hard working people are told to pick a new doctor because the boss has had to pick a new plan. And countless others turn down better jobs because they know if they take the better job they'll lose their health insurance. If we continue to let the health care system continue to drift, our country will have people with less care, fewer choices and higher bills.

Now, our approach protects the quality of care and people's choices. It builds on what works today... in the private sector. To expand employer based coverage, to guarantee private insurance for every American. And I might say, employer based, private insurance for every American was proposed 20 years ago by President Richard Nixon to the United States Congress. It was a good idea then, and it is a better idea today.

Why do we want guaranteed private insurance? Because today, nine out of ten people who have insurance get it through their employer, and that should continue.

Our goal is health insurance everybody can depend on. Comprehensive benefits that cover preventive care and prescription drugs; health premiums that don't just explode when you get sick or older; the power, no matter how small your business is, to choose dependable insurance at the same competitive rates that government and big

business get today; one simple form for people who are sick; and most of all, the freedom to choose a plan and the right to choose your own doctor.

When it's all said and done, it's pretty simple to me: Insurance ought to mean what it used to mean: you pay a fair price for security, and when you get sick, health care is always there.

Along with the guarantee of health care security, we all have to admit too that there must be more responsibility on the part of all of us on how we use this system. People have to take their kids to get immunized; we should all take advantage of preventive care; we must all work together to stop the violence that explodes our emergency rooms; we have to practice better health habits, and we can't abuse the system.

### **Campaign reform AND health care reform**

I know that facing up to these interests will require courage. It will raise critical questions about the way we finance our campaigns and how lobbyists wield their influence. The work of change, frankly, will never get any easier until we limit the influence of well-fiance interests which profit from this current system. So I also must call on you now to finish the job both houses began last year by passing tough and meaningful campaign reform and lobbying reform legislation this year!



*"You know, my fellow Americans, this is really a test for all of us. The American people provide those of us in government service with terrific health care benefits at reasonable cost. We have health care. It's always there. I think we need to give every hard-working, taxpaying American the same health care security they have already given to us."*



# Colorado Medical Society Interim Meeting Schedule

March 4-6, 1994

## To be held at the CMS offices:

### FRIDAY, MARCH 4, 1994

12:00 N .... 1:30 pm	Finance Committee
2:00 pm .. 5:00 pm	Board of Directors
6:30 pm .. 9:30 pm	Women in Medicine

## To be held at the Sheraton DTC Hotel:

### FRIDAY, MARCH 4, 1994

7:00 pm .. 9:00 pm	Colorado Chapter, American Medical Directors Association
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### SATURDAY, MARCH 5, 1994

7:00 am 10:00 pm	Office open
6:30 am .. 5:00 pm	Registration
7:00 am .. 8:30 am	Reference Committee Members
7:00 am .. 9:00 am	Nominating Committee Open Forum
8:30 am .. 9:00 am	Credentials Committee
9:00 am .. 9:30 am	House of Delegates Opening Session
9:30 am 11:45 am	General Membership Meeting— Keynote: Richard Seaman, MD, President, Washington State Medical Association

12:00 N .... 1:30 pm

1:30 pm .. 2:30 pm

2:30 pm .. 5:00 pm

4:00 pm .. 6:00 pm

Luncheon—Speaker: Robert Brittain, MD

Informational Session: "Sponsorship of a Statewide Physician Network"

Reference Committee on Board of Directors/Constitution, Bylaws and Credentials

Reference Committee on Health Affairs

### SUNDAY, MARCH 6, 1994

7:00 am 12:00 N

6:30 am 11:00 am

7:00 am .. 8:30 am

7:00 am .. 8:30 am

7:00 am .. 8:30 am

7:00 am .. 8:30 am

7:00 am .. 8:30 am

7:00 am .. 8:30 am

7:00 am .. 8:30 am

7:00 am .. 8:30 am

8:00 am .. 8:30 am

8:30 am 12:00 N

8:30 am 12:00 N

Office open

Registration

Arapahoe caucus

Aurora-Adams caucus

Boulder caucus

Clear Creek Valley caucus

Denver caucus

El Paso caucus

Larimer/Weld caucus

Pueblo/Western Slope caucus

Credentials Committee

House of Delegates Closing Session

Alliance Educational Program

## You are Invited to Attend the Women in Medicine

Interim Business Meeting and Dinner  
on March 4, 1994 6:30 p.m.

at CMS Board Room 7800 E. Dorado Place, Englewood, Colorado

We are happy to announce that Kathy Buys, Vice President of Investments at Chase Manhattan Investment Services, Inc. will be the featured speaker. She has been active with the Physician's Financial Program throughout the state and speaks on topics ranging from

retirement planning to global investing. She will give us her perception of what interest rates and inflation will be in 1994, and which investments can be expected to do well.

Kathy has given many seminars, speeches and classes, and is an

ongoing contributing author for the Denver Post. We think you will find her presentation enjoyable and educational - plan now to attend.

Registration forms are available in the WIM newsletter or you can call Marilyn Barton at 779-5455 or 1-800-654-5653. Cost is \$15.

## OFFICIAL CALL FOR NOMINATIONS

The Colorado Medical Society Nominating Committee is seeking nominations for the following elected positions for the 1993-94 term of office.

PRESIDENT-ELECT (from out-state)  
SPEAKER OF THE HOUSE

VICE SPEAKER OF THE HOUSE

AMA DELEGATE (two)

AMA ALTERNATE DELEGATE (two)

Please contact Dr. Ronald E. Tegtmeyer, Chair, at (303)278-2600 or Mary Lee Johnston, CMS staff, 1-800-654-5653 or (303)779-455 with

names of interested persons. The Nominating Committee will be meeting during the President's Planning Conference in Longmont, Colorado on July 16-17, 1993 to interview prospective candidates or at another time if necessary.

# INTERIM MEETING REGISTRATION

1994 Interim Meeting of the Colorado Medical Society, March 5-6, 1994, Sheraton Denver Tech Center Hotel

Name (please type or print) \_\_\_\_\_

Name of Spouse/Guest (if attending) \_\_\_\_\_

Component Society \_\_\_\_\_ Office Phone \_\_\_\_\_

Please check all that apply

<input type="checkbox"/> Women in Medicine Section	<input type="checkbox"/> Young Physicians Section	<input type="checkbox"/> Resident Physicians Section	
<input type="checkbox"/> Component Society Executive	<input type="checkbox"/> Program Speaker	<input type="checkbox"/> Press	<input type="checkbox"/> Other _____ _____

If you are not a member of CMS, please provide the following:

Company/Organization \_\_\_\_\_

Title \_\_\_\_\_

## Be sure to complete both sides of the form

## Send top part of form to CMS

## Send bottom part of form to hotel

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Organization Name **Colorado Medical Society**

Meeting Dates **March 5-6, 1994**

Q-Name \_\_\_\_\_

Guest Arrival Date \_\_\_\_\_

Guest Departure Date \_\_\_\_\_

No. of Persons \_\_\_\_\_

## Complete both sides before mailing



## RESERVATIONS FOR EVENTS AND MEETINGS

(Reservation deadline is February 18, 1994. Reservations accepted on a first-come, first-served basis.)

SATURDAY, MARCH 5, 1994

12 Noon-1:30 pm Luncheon

NUMBER OF  
RESERVATIONS

AMOUNT  
ENCLOSED

Complimentary

### HOTEL RESERVATIONS

Please use the hotel reservation form below to make your reservations directly with the Sheraton Denver Tech Center Hotel. **The deadline for room reservations is February 18, 1994.** The preferred rate will be extended to CMS members on a space available basis after February 18.

### MEETING REGISTRATION

**Please submit a registration form by February 18, 1994, if you plan to attend this Interim Meeting.** We're delighted to receive it by mail, fax, or phone. We can check you in more quickly and efficiently if you've preregistered, in addition to providing more accurate and therefore cost-saving guarantees for our food functions. Thanks!

### MESSAGES

For your convenience, a message board will be provided at the CMS registration desk. The hotel's phone number is 303-779-1100. (You may want to leave this number with someone). If you need to be contacted, ask the hotel operator to transfer the call to the CMS registration desk or CMS office.

### WHAT TO DO

Complete both sides and return to Colorado Medical Society, PO Box 17550, Denver, CO 80217 (303-779-5455 or 1-800-654-5653), or FAX to 303-771-8657.

# Send top part of form to CMS

# Send bottom part of form to hotel

Room type, location and rate subject to availability at time of request. *Indicate preference and mail early.*

Guest room:

☐ Single \$75.00

☐ Double \$85.00

☐ Non-Smoking Room (subject to limited availability).

☐ 1 Bed

☐ 2 Beds

☐ Handicapped Accessible (1 Bed Only)

*Suites and concierge floor available upon request. Please contact hotel directly for rates.*

Estimated time of arrival at hotel \_\_\_\_\_

To guarantee room for arrival, please complete A or B:

(A) Amount of enclosed check \$ \_\_\_\_\_

(B) ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DINERS CLUB ☐ DISCOVER

Credit Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_

Confirmation is based on scheduled arrival date availability. All rates subject to tax. Currently 11.8%.

**Request and deposit must be received by February 18, 1994.** Deposit refunded if cancellation is received 48 hours prior to arrival. Check-in time and guest room availability are 4:00 p.m. Checkout time is 1:00 p.m. Please arrange travel plans accordingly. Baggage storage available for earlier arrival.



# Reform Expert to Keynote IM '94

## Statewide IPA similar to one envisioned by CMS

**Richard W. Seaman, MD**, an Olympia, Washington Otolaryngologist, will present the keynote address at the CMS General Membership Meeting on Saturday, March 5. Dr. Seaman is President of the Washington State Medical Association (WSMA) which represents more than 8,100 of Washington's practicing physicians and surgeons.

Dr. Seaman has been involved in Washington State Medical Association activities the past ten years. As President-Elect, he was instrumental in 1992 in drafting a proposal that became WSMA's offering to the state legislature. It included an individual mandate and either a premium cap or benefits float but not both. The bill was submitted and negotiated into the Washington Health Reform Act of 1993 adopted by the legislature.

In January 1993 WSMA's Marketplace Response Task Force was established by their Board of Directors. From January through May Dr. Seaman and the WSMA worked to determine how best the Association could help its members. Should they set up an insurance plan? a network? a cooperative? At the May Board meeting physician market research was authorized for a plan to be called the Certified Health Plan (CHP). In September the House of Delegates approved a report to establish the CHP but also autho-

rized additional research and a business plan to be presented at a special House meeting on February 5, 1994.

This concept is similar to the statewide IPA currently being researched by CMS. Saturday afternoon there will be an informational session on CMS sponsorship of a statewide physician network. This is intended to acquaint physicians with the state of current research and plans in Colorado.

Dr. Seaman is a board certified otolaryngologist in private practice in Olympia. He is a staff member at St. Peter Hospital, where he serves on the Community Board.

Dr. Seaman's professional affiliations include memberships in the Thurston-Mason County Medical Society and the American Medical Association. He is a Fellow of the American College of Surgeons and the American Academy of Otolaryngology Head and Neck Surgery. He also is a Diplomate of the American Board of Otolaryngology.

Dr. Seaman received his undergraduate and medical degrees from the University of Washington and completed his residency at Fitzsimons Army Medical Center in Denver.

Dr. Seaman and his wife, Sharon, have three children and live in Olympia, Washington.

### CMS Alliance to sponsor *Physician's Financial Program* seminar at '94 Interim Meeting

As you are aware, the Colorado Medical Society has joined with Chase Manhattan to provide the **Physician's Financial Program**.

We are happy to announce that Kathy Buys, Vice President of Investments at Chase Manhattan Investment Services, Inc., will be our featured speaker at our meeting on March 6, 1994. She has been active with the **Physician's Financial Program** throughout the state and speaks on topics ranging from retirement planning to global investing. She will give us her perceptions of what interest rates and inflation will be in 1994, and which investments can be expected to do well.

Kathy has given many seminars, speeches, and classes, and is an ongoing contributing author for the Denver Post. We think you will find her presentation enjoyable and educational, so plan now to attend.

*Pam Laman, President  
CMS Alliance*





by Thomas H. Coleman MD  
Denver, Colorado



### A sick health plan...dead on arrival, we hope!

At the end of the old year and near the beginning of the Clintons' second I watched a CNN tape of the "live" Larry King interviewing the clear-eyed Hillary Rodham Clinton about her vision thing for health care in America. She was her please-everybody self, promising to bring the left and the right together with the center, to bring the doctors, insurance companies and drug makers together with the bureaucrats in mutual respect and nobility for the good of the people. She claimed that her miracle will happen in September if the Congress will simply pass her husband's bill.

She said she wants to free doctors from interference by insurance companies, and from excessive paper work. She wants to give them a single universal form on which to claim their fees. Later in the interview she said that instead of fees she wants to pay them with salaries, "like they do at the Mayo Clinic". She did not offer doctors any federal protection against unwarranted lawsuits and exorbitant court judgments.

She was disturbed and appalled by the cost of surgical operations, medical services, hospital care, new drugs, and by insurance companies who don't insure. She offered to pay for everyone's medicines, for long term treatment of mental disorder, for surgery, for hospital care. Everything for everyone would be controlled through a complex network of insurance companies, limited HMOs and platoons of clerks, with no freedom of choice for patients and doctors.

She never mentioned Medicare, an extravagant government insurance bureaucracy that will continue to interfere with the professional decisions of doctors, harass them with reams of paper work, control their incomes, cost patients higher premiums. Yet she was asking Americans to accept her colossal new bureaucracy, parallel and redundant to Medicare, that will further burden all businesses with rising insurance premiums and destroy the quality of medical care by rationing.

During the interview Mrs. Clinton appeared intelligent and articulate,

ingenuous and neatly feminine, so sincere and animated that it was hard to believe she was pretending not to know about the outrageous penalties and extravagances in her plan. Those were revealed recently by two researchers, Professor Bradley Smith of Capital University Law School in Columbus Ohio, and Daniel J. Mitchell, a Fellow of the Heritage Foundation. As guests of the Wall Street Journal on December 16 and December 23, 1993 they wrote about their discoveries.

Professor Smith found that written into the Clintons' law are fines and prison sentences for anyone involved in health care, especially patients and doctors. He discovered that the Clintons would pay incentive fees to federal prosecutors for bringing charges against anyone for "health care offenses" (a term their law does not define), to secure convictions, confiscate personal and business money and property and turn those assets over to the inspector general to finance more

investigations. For example, it would be a federal crime, with ten years in prison, for a doctor or a patient to be involved in "bribery" for medical care. Smith correctly infers that "bribery" could arise only inside a health plan that mandates restrictive rationing of care, a restriction the Clintons never mention except to deny it.

Mr. Clinton says that in six years his universal medical entitlement would reduce the cost of American medical care and simultaneously reduce the national deficit by \$58 billion. Mr. Mitchell merely quotes Mr. Clinton's own actuaries and economists in the Office of Management and Budget who show that the Clinton plan would actually increase our national budget deficits in six years by **eight hundred** billion dollars. That would bankrupt health care, industrial companies, and the economy too.

Maybe it should be no surprise that a socialist-minded president writes a law containing enforcements and punishments of a severity we would expect to see in a police state, and that he misrepresents the cost of his program, but for his wife to engage the media in a campaign of inspirational speeches pretending she knows no evil is either stupidity or plain deceit. Mrs. Clinton did not appear stupid.

Senator Dole says the Clintons' health care bill will be dead on arrival at the doors of Congress. Let's hope no one will try to resuscitate it. Just bring it inside to the undertakers where a surgeon can fire its escort of federal marshals, salvage a few of its usable parts, and let the Congress start over.



# Immunization News

## Vaccine Information Charts Available

-To aid in the effort to fully immunize all preschool children, the Colorado Children's Immunization Coalition is making available to health care providers easy-to-read charts containing vaccine information. Designed to be posted in providers' offices and exam rooms the three charts are: the recommended schedule of pediatric immunizations, a guide to contraindications and precautions for each recommended vaccine, and a list of real and false contraindications by symptom or condition.

Also, available is a booklet containing standards for pediatric immunization practices which were developed by the National Vaccine Advisory Committee. These standards represent a consensus of the major professional societies and agencies involved with immunization practice standards. Fifteen standards are recommended by the Committee. Three of those standards merit special attention. They are:

Standard 4 - "Providers utilize all clinical encounters to screen for needed vaccines and, when indicated, immunize children."

Standard 7 - "Providers follow only true contraindications."

Standard 8 - "Providers administer simultaneously all vaccine doses for which a child is eligible at the time of each visit."

The three charts and standards booklet are available free of charge through the Colorado Children's Immunization Coalition, 303-692-2794.

## Immunization Materials Available at an Easier Reading Level

-Materials about childhood immunization and Hepatitis B are now available at a lower reading level than other materials previously offered. To obtain these materials call Frances Pineda at the Colorado Department of Health 692-2677.

## Influenza Vaccine Covered by Medicare

-The cost of the influenza vaccine and its administration became a covered Medicare benefit on May 1, 1993.

## AAP Immunization Policy Changes

By Judy Conner

from Communique (CDH)

-In the September 3, 1993 issue of *Pediatrics*, the Committee on Infectious Diseases of the American Academy of Pediatrics (the "Red-book" committee) updated their statement on *Haemophilus influenzae* type b (Hib) conjugate vaccines to include recommendations for use of a newly-licensed Hib vaccine and the combined Hib/DTP vaccine.

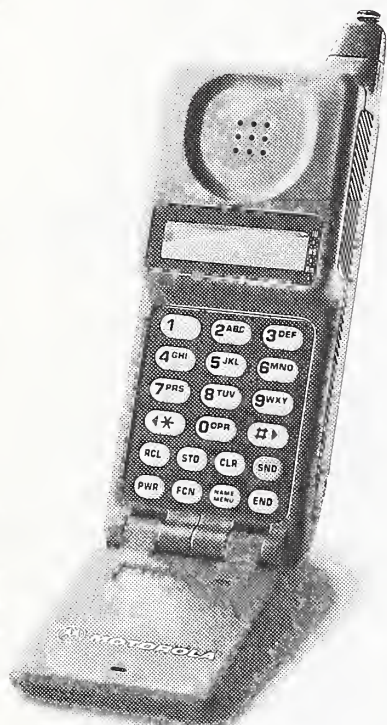
Although they still recommend using the same brand of conjugate Hib vaccine for all doses in a primary series for children younger than age 12 months **when feasible** they also say that for infants given doses of different conjugate vaccines, it is not necessary to give more than three doses of any vaccine to complete the series. (The previous recommendation was to restart the series if the same vaccine brand was



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not available for use as subsequent doses in the series.)

## Physicians Needed For Immunization Coalition Speakers Bureau

The Colorado Children's Immunization Coalition wishes to add physicians to their speaker's bureau. They are seeking physicians who will volunteer time to present current immunization information and recommendations to their colleagues at professional society meetings and/or hospital departmental meetings. The Coalition will provide educational materials for speakers to use such as outlines, objectives, overheads, slides, and handouts.

Interested physicians should call Lori Stonehocker Quick at 692-2794.

## CDC Vaccine Information by FAX or Telephone

Vaccine information is now available through the Centers for Disease Control's automated fax and voice system. The system, which is accessible by touch-tone phone, is available twenty-four hours a day and provides the most up-to-date information regarding immunizations. Callers can receive written information immediately by fax, listen to the information, or ask to receive information by mail.

The CDC FAX Information system provides step-by-step instructions to guide callers to receive either a directory of available topical information, or specific FAX documents. When calling the FAX Information Service, individuals should have their fax number available. *The FAX system allows callers to request up to five documents at a time. To receive a FAX document call (404)332-4565.*

The directory of documents available to health care workers follows:

### Measles Information

- 241101 Post Exposure Information
- 241102 Vaccine Information
- 241103 Side Effects
- 241104 Recommendations for the Immune Suppressed
- 241105 Diagnosis
- 241106 Outbreak Control

241107 Pregnancy

### Mumps Information

- 242101 Vaccine Information, Diagnosis, Outbreak Information

### Rubella Information

- 243101 Vaccine
- 243102 Inadvertent Use of Rubella Vaccine During Pregnancy
- 243104 Congenital Rubella Syndrome (CRS)
- 243105 Testing and Diagnostic Information

### Diphtheria Information

- 244101 Prevention Among Close Contacts
- 244102 Pregnancy
- 245103 Diagnosis and Treatment

### Tetanus Information

- 245101 Vaccine Information
- 245102 Pregnancy
- 245103 Wounds

### Pertussis Information

- 246101 Diagnosis Treatment of Cases and Contacts
- 246102 Vaccine Information
- 246103 Pertussis Vaccine Controversy

### Hib Information

- 247101 Vaccine Information
- 247102 Outbreaks
- 247103 Diagnosis and Treatment

### Varicella Information

- 248101 VZIG-Varicella-Zoster Immune Globulin
- 248102 Post-Exposure Situations
- 248103 Treatment and Diagnosis

### Poliomyelitis Information

- 249101 elPV Vaccine Information
- 249102 Travel Recommendations and Polio Vaccine
- 249103 Adult Immunization Information
- 249104 OPV or elPV. Advantages and Disadvantages
- 249105 Recommendations for the Immune Suppressed

### Hepatitis Information

- 361300 General Information
- 361350 Hepatitis B Vaccine Information
- 361351 Universal Infant Hepatitis B Immunization

To Access the Immunization Voice Information System Call (404)332-4553. To Access the CDC Voice General Information System Which Contains Other Topics Besides Immunizations Call (404) 332-4555.



Health System Reform  
Comparative Analysis

Prepared by the Colorado Hospital Association

	Colorado Hospital Association	Denver Chamber of Commerce	Colorado Association of Commerce and Industry	Employer Coalition and National Federation of Independent Business	Colorado Group Insurance Association	Colorado Springs Chamber of Commerce	Colorado Medical Society
Supports Universal Coverage, Basic Benefits	YES	YES	YES	YES	YES	YES	YES
Supports Public/Private Delivery & Financing	YES	YES	YES	YES	YES	YES	YES
Supports Insurance Reform	YES	YES	YES	YES	YES	YES	YES
a. Uniform Billing	YES	YES	YES	YES	YES	YES	YES
b. portability	YES	guaranteed access	guaranteed access	guaranteed access	guraanteed access	portability and guaranteed access	YES
c. community rating	YES	revise underwriting practices	revise underwriting practices	revise underwriting practices	small group underwriting reform		
d. no preexisting	YES	YES	YES	YES	limit preexisting	YES	YES
e. uniform UR	YES	YES	YES	YES		YES	YES
f. limited # of payers	YES						no limit on # of payers
g. uniform disclosure of administrative costs and commissions					PRESUMED		
Supports Multiple Sources of Financing	YES	YES	PRESUMED	PRESUMED		YES	YES
Supports Employer Mandate	YES	NO Supports Individual Mandate	NO Supports Individual Mandate	NO Supports Individual Mandate	Continue Employment Based Plans & Individual Responsibility Model	Supports Individual Mandate	Supports Eliminating Employer Based Insurance
Supports Individual Participation in Payment & Greater Personal Responsibility, Healthy Lifestyles	YES	YES	YES	YES	YES	YES	YES
Supports Expanded Consumer Education & Information	YES	YES	YES	YES	YES	YES	YES
Supports Cooperation/Collaboration to Reduce Excess Capacity	YES	YES	YES	YES	YES	YES	YES
Supports Cost Containment	YES	YES	YES	YES	YES	YES	YES
Supports Change in Provider Payment Methodology to Create & Align Provider Incentives	YES		YES	YES	YES	YES	YES
Supports Malpractice/Tort Reform	YES	YES	YES	YES	YES	YES	YES
Supports Antitrust Reform	YES	YES					
Supports Legislation to Create Voluntary Purchasing Groups			YES	YES			
Supports Public Financing & Delivery for those not Employed or Unable to Work	YES	YES	YES	YES	YES	YES	YES
Supports Reduction/Elimination of Cost Shifting		YES	YES	YES	YES		YES
Supports Equitable Government Taxing Policies re: HC Insurance & Costs		YES	YES	YES	YES		
Supports Elimination of Conflict of Interest in Medical & Other HC Decision Making		YES	YES	YES	YES	YES	
Supports Monitoring & Evaluation of Quality & Outcomes Research		YES Plus comparative norms	YES Plus comparative norms	YES Plus comparative norms	YES, Provider Practice Patterns Disclosure		YES
Supports Freedom of Choice							
Supports Multiple Payers	YES	YES	YES	YES	YES	YES	YES





# Medicaid . . . Automation

*This report compiled from information supplied by  
the Colorado Department of Social Services*

*The Colorado Medicaid Program has announced to Colorado Medical Society development of a totally electronic claim submission and eligibility verification system, the **Automated Medical Payments (AMP)** system, which will be available to providers during the summer of 1994. Indications are that this system offers greater claim submission efficiency and improved cash flow.*

## Background

The national focus on burgeoning administrative cost in health care served as a springboard for the Colorado Legislature in Senate Bill 93-122 to direct development of an interactive electronic eligibility verification and claims submission system that promises to reduce claim filing hassles and expedite claim payments to Medicaid providers.

The Colorado Department of Social Services initiated development of the Colorado Automated Medical Payments (AMP) system in August 1993. Phased-in implementation is scheduled to begin in July 1994 with state-wide completion in November 1994 when, with few exceptions, all Colorado Medicaid claims will be submitted electronically.

### AMP Features and Benefits to Providers

Guaranteed Medicaid eligibility information is accessible through a personal computer using individual's Medicaid state identification number or social security number. Instant access to eligibility information protects providers when Medicaid recipients fail to bring their Medicaid Card to appointments. AMP also offers enhanced information when other insurance benefits are available. Reduced claim denial rates result from using interactive on-line claim completion assistance and real-time transaction processing that promotes transmission of complete and accurate claim information. Diminished paper claim handling, microfilming and data entry functions create reduced claim processing time.

Streamlined claim filing requirements eliminate claim attachments and allow most claims to be filed electronically.

Same day claim reversal capability allows providers to withdraw incorrect accepted claim transactions, make necessary adjustments, and, when appropriate, retransmit a revised claim.

Providers who currently do not bill electronically will receive the necessary support to develop automated claim transmission capability and the potential for future application to other types of electronic billing. Enrolled providers who bill Medicaid regularly but do not have computer capability will receive additional assistance from the Medicaid Program which will allow them to submit claims electronically.

Pharmacy providers benefit from on-line prospective drug utilization review and on-line pharmacy claim adjudication with immediate identification of Medicaid payment and co-payment amounts. Providers profit from rapid access to Medicaid payments through electronic funds transfer and improved timeliness in posting accounts from electronically transmitted remittance statements.

No cost software and programming specifications furnished to providers.

Colorado Medicaid providers will submit AMP claims in two ways:

### • **Interactive submissions**

Providers using their personal computer with software furnished by the Medicaid Program at no cost to the provider, claims are entered one-at-a-time and claim information is subjected to interactive editing and on-line, real-time transaction processing (immediate notification of claim acceptance or rejection).

### • **Batch submissions**

Transmission of a group of specially formatted claim records with rapid transaction processing. Accepted and rejected transactions are posted to an electronic bulletin board for retrieval. Under this option, using specifications provided by the Medicaid Program, billing services, software vendors and providers will be able to program accounting and claim preparation packages to transmit Medicaid required information and to receive electronic claim information.

Providers who already bill electronically may continue using the existing Electronic Medicaid Claims (EMC) submission process. Providers will want to reprogram their systems to benefit from the AMP enhanced features.

When the AMP system is fully implemented, electronic claim submission will, with few exceptions, be required for all claims. Only those claims that continue to require attachments will be accepted on paper.

## AMP Funding

Funding for development and maintenance of the AMP system is derived from a combination of Federal dollars, State funds, and returned administrative savings from the fiscal agent contract. Ongoing AMP expenses will be funded through provider transaction fees of 12C for eligibility verification, 17C for pharmacy claim transactions, and 30C for all other claim transactions. There are no transaction fees for claim reversals. Transaction fees will be deducted from provider claim payments.

## AMP Implementation

Recognizing the critical need to have a smooth transition to the automated system, the Medicaid Program has designed the AMP implementation plan to be phased in over a four month period. Beginning in July 1994, the fiscal agent's program representatives will, in 28 locations throughout the State, conduct interactive demonstrations of the AMP software and discuss billing policy changes. The unique nature of the AMP demonstration which features hands-on participant practice requires that attendees make advance reservations and limit attendance to a maximum of two representatives for each billing provider. Providers should watch for the AMP training bulletin and make reservations promptly.

## Provider Support

The Colorado Medicaid AMP System is seen as a significant first step in addressing administrative costs and moving to a more uniform claim submission environment.

# Leave it to the Tobacco Industry to call inhaling forty-three known carcinogens “refreshing”.

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<b>Cyanide:</b>	the deadly ingredient in rat poison
<b>Formaldehyde:</b>	the foul smelling preservative found in dead laboratory frogs
<b>Ammonia:</b>	a powerful cleaning agent and poisonous gas used to clean floors and toilets
<b>Arsenic:</b>	a potent ant poison
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Sources: US Dept. of Health and Human Services, US Surgeon General Report 1989, Environmental Protection Agency

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# P

# rovider Integration in Colorado -- A Primer

## Introduction

Colorado health care providers are establishing innovative new business relationships to better compete in the changing health care marketplace. Physicians are exploring ways to combine their resources to promote practice efficiency and professional success in a managed care environment. Hospitals are seeking to establish new alliances with physicians to preserve and enhance their own market niche.

In many communities, hospitals and physicians are working together to create coordinated networks often labelled "integrated delivery systems" ("IDSs"), as more comprehensive health care delivery systems.

This article outlines the principal features, strengths and weaknesses of several of these models of health care integration in the context of Colorado's current legal environment.

## Clinics "Without Walls"

The clinic "without walls" ("CWOW") model (Exhibit A), allows physicians to combine their practices into a single group practice while maximizing individual practice autonomy. A separate physician-owned professional corporation serves as the CWOW's legal "superstructure". The physicians' medical practices become unincorporated operating divisions of the CWOW, and remain physically located in the individual physicians' geographically dispersed offices. The CWOW's board of directors retains ultimate authority over the organization and the CWOW's centralized management, but each operating division remains locally managed, thus enhancing medical practice autonomy and control.

CWOWs provide a higher level of economic and functional integration among participating physicians than generally exists in PPOs and more loosely affiliated provider groups. This more significant integration is important to enhance compliance with antitrust, fee splitting, Medicare/Medicaid fraud and abuse, ancillary service referral and other legal issues. It also enables the group to engage in collective contract negotiations and provide benefits not available outside of a group practice.

## Management Services Organizations

Management Services Organizations ("MSOs") provide administrative and related support services to physicians and hospitals (Exhibit B). In an MSO, individual providers are brought

together through their ownership interests in the MSO, and through the MSO's centralized practice support services. Practitioners maintain their present medical practices and maximize autonomy, while enjoying significant benefits through the MSO's practice support activities.

Customarily, MSOs are owned solely by hospitals or physicians, or jointly by both groups. The promotion of stronger ties among individual and institutional providers through joint ownership arrangements is consistent with the development of more vertically integrated health care delivery systems.

The economic integration among a MSO's participating providers may be insufficient to permit the MSO without more, to engage in collective contract negotiations with third party payers in a manner which does not risk violating antitrust laws. Thus, MSOs are often confined to providing collective purchasing, management and administrative services. Moreover, since physicians maintain their existing practices, several legal restrictions prohibit any division of patient fees or distribution of profits resulting from referrals among the MSO's providers.

## Physician-Hospital Organizations

Physician-hospital organizations ("PHOs") integrate physicians and hospitals through a separate, jointly-owned and managed organization (Exhibit C). The vertically integrated PHO customarily engages in collective contract negotiations with third party payers, utilization review,

\* Gerald A. Niederman is a partner and Bruce A. Johnson is an associate in the Health Care Practice Group of the Faegre & Benson law firm in Denver.

quality improvement and related programs on behalf of its provider owners. The RHO may also create panels of providers who share risk through capitation and other payment methodologies. As a physician/hospital joint venture, a PHO can offer a more comprehensive health care product to third party payers for managed care contracting purposes.

The PHO's participating physicians may maintain their existing practice formats, or participate in the PHO through one or more physician groups. Thus, aside from the medical management and related standards which the PHO may impose for contracting purposes, practice autonomy of the PHO's constituent providers can largely be maintained.

### Hospital-driven IDSs

Recent changes to Colorado's corporate practice of medicine doctrine permit the creation of hospital-driven, vertically integrated health care systems in certain rural communities. Hospitals in counties with populations of less than 100,000 persons can now legally employ physicians in a "hospital-driven IDS", thus enabling the hospital to offer a comprehensive health care delivery product to third party payers.

The primary weakness of the hospital-driven IDS is its potential to decrease physician autonomy. Moreover, because the model is entirely hospital-driven, it is more difficult for the sponsoring hospital and the participating physicians to share in the ultimate risk of financial profit or loss.

### Medical Foundations

So-called "medical foundations" represent the latest hot topic in provider integration (Exhibit D). Foundations achieve nearly total hospital/physician integration because a tax-exempt, hospital-sponsored foundation generally purchases all of the participating physicians' practice assets. The physicians, in turn, deliver medical services either for the foundation, or indirectly through a separate group practice which contracts with the foundation. The foundation typically owns all of the accounts and revenues derived from patient care, and pays the physician providers, either individually or as a group, for their professional services.

Although increasingly popular in California, foundations operate in that state pursuant to a specific exception from California's corporate practice of medicine prohibition. Colorado legal restrictions restrain the application of the California-style foundation model in this state, although other variations on the model may be feasible.

### Conclusion

In today's changing health care marketplace, physicians and hospitals will be well counselled to be proactive in positioning themselves for increased competition. These five IDS models may be modified or combined to meet providers' business and professional needs. One model cannot be prescribed as a standard cure for the unique problems and needs arising in different communities. Rather, a case-by-case diagnosis and treatment is required to address the participants' varying goals. The various forms of provider integration outlined above may provide useful vehicles to promote progress and enhanced control during the uncertain ride that lies ahead.



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## Sports Medicine Compendium Released

A *Compendium of Sports Medicine Statements and Guidelines* written or approved by the Joint Sports Medicine Committee of the Colorado Medical Society and the American Academy of Pediatrics is now available. Included in the *Compendium* are the widely-known

*Guidelines For Management of Concussion in Sports*, suggestions for a range of emergency medical equipment/personnel that ought to be available at school sporting events, HIV in Sports statements, a recommended pre participation sports physical form and suggestions for a medical hierarchy on the playing field.

The *Compendium* is available free to Colorado Medical Society members and for \$3.00 to nonmembers. To obtain a copy please call Lynn Livingston or Marilyn Barton at (303)779-5455 or 1-800-654-5653 or, write to the Colorado Medical Society, PO Box 17550, Denver, CO 80217-0550.

## Concussion Video Now Available

*When The Cheering Stops*, a two-part video and accompanying manual, was recently produced by the Rocky Mountain Regional Brain Injury Center. Based on the Colorado Medical Society Sports Medicine Committee's *Guidelines For Management of Concussion In Sports*, the video provides information on the evaluation of concussions which occur during the course of a sporting event as well as recommendations on how soon following a concussion an athlete should be returned to play. The video was developed primarily as a tool for coaches, athletic trainers and physical education teachers.

The video and manual are available free from the Rocky Mountain Regional Brain Injury Center. To order a copy call Dianne Primavera, Training Coordinator at

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\*Reprinted from the December, 1993 *Colorado Disease Bulletin*

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The Colorado Physician Health Program will hold its Annual Meeting April 22 at Marriott West, 1-5 pm. The topic will be Disruptive Behaviors. For more information call 860-0122.





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## RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor



F. E. Townsend, M.D.

Not long ago, I was going through some of my "treasures". One is a book I have appreciated many years. It was written and given to me by the late O. Otto Moore, former Chief Justice of the Colorado Supreme Court. Otto Moore was a man for whom I had a great admiration as a human and as a jurist. I got to know him when I was a reporter, then as an editor and then just as someone I really liked. Justice Moore would always "tell it like it was". You didn't have to agree with him... but you could appreciate his speaking his mind.

Justice Moore wrote "*Mile High Harbor*", the story about his involvement (at the ripe *old* age of 26) in the cause of the elderly, and then his getting snared in the *Townsend Plan*, working with the National Annuity League and finally seeing Colorado's "Old Age Pension" Amendment XXIV written into the Colorado State Constitution.

It's a fascinating story on its own, about the many hurdles and grinders you must go over or through getting legislation into law. As I reread it tho I was struck by the pie-in-the-sky similarity between the Townsend Plan and one of our present-day welfare plans.

- **In those days** it was a physician;
- **Today** it's the President's spouse.
- **In those days** it was hope and promise for the old age people;
- **Today** it's holding out hopes and promise for people of all ages.
- **In those days** the best that could be said was that the plan was the product of a beautiful, fanciful dream, well-intended but without study or factual basis.
- **Today** the best that can be said is that the plan is a beautiful dream, well-intended but without study or factual basis.

**In those days** (circa 1934) it was called the "Townsend Plan" dreamed up by a west-coast physician, F. E. Townsend, to provide every citizen of the United States over 60 years of age a minimum of \$200 per month old age pension. In 1934 when the nation was being racked by the so-called "Great Depression", Townsend's dream looked like the savior for so many. Granted, we didn't have as large an "old age" population then as now, but in Colorado alone there were over 40,000 people over 60 years of age. Can you imagine? 60 was considered "old age." In his appeal to the Ways and Means Committee, Townsend could not provide a shred of evidence that the United States government could pay for any such scheme, and offered no financing plans or solutions.

**Nowadays** (circa 1992 and since) the "Clinton Plan", dreamed up by a campaign team and furthered by President Clinton and spouse, says that everybody, regardless of anything, will receive some level or degree of health care no matter their ability to pay, and that this care will be adminis-

tered by some "health care giver" (probably **NOT** a physician) and paid for through some combination of "Hic-Pics" who have been entrusted with buying the most health care at the least expense, regardless of quality and without any patient choice of provider or plan. In the appeal to Capitol Hill, Clinton could not provide a shred of evidence that the United States government could pay for any such scheme, and offered no financing plans or solutions.

Of course, it wasn't too long after Townsend was run out of Washington that the National Social Security Act was enacted, and pensioners were given the assurance that Social Security would always be there as a small but secure "safe harbor" to help in the twilight years. The program (for the time) at least had a plausible method of paying for the program. As we compare Social Security (I did not say Medicare) to many other federal programs, it was actually a good model for government welfare. There is no similarity to the Clinton Health Care Plan, but there is a remarkable similarity between the "Clinton Plan" and the "Townsend Plan".

When he saw through the Townsend Plan, the young attorney O. Otto Moore came back to Colorado and went on with his fight to secure the Colorado Old Age Pension program and to amend the Constitution to protect the elderly. That plan probably saved hundreds, even thousands of lives. I can think of one or two whom I felt, at the time, couldn't have made it without. It was truly a "*Mile High Harbor*". Attorney, judge, justice, arbiter and humanist O. Otto Moore was its chief architect.



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March 1994

Volume 91, Number 3

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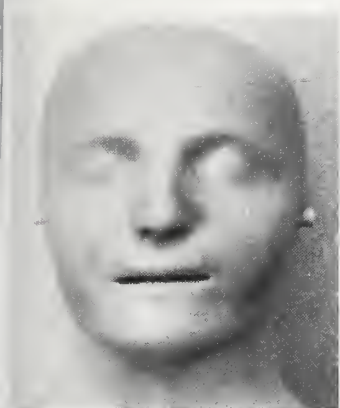
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Only a physician can adequately explain the issues involved in a CPR Advance Directive. That's why the Board of Health chose YOU to administer the program. Page 100



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# Computer Talk

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Today we take pretty much for granted the great strides in reliability the computer industry has made in the past five years. Not only are the current systems considerably freer from failures than their predecessors, backing them up has become faster, simpler and in some cases even automatic.

But the price we pay for this sense of security regarding backup procedures can be very high. Like the heart attack whose very first symptom is sudden death, the importance of prevention is often underappreciated until it's too late. Then finger pointing and the biblical "wailing and gnashing of teeth" can quickly rise to heights previously undreamed of.

Could your system be one of these accidents waiting to happen?

Recently a local medical practice experienced an accidental loss of data. The damage was caused by an experienced computer manager - someone who ostensibly "knew better." Well, these things can (and do) happen to anybody. At least there was a backup.

But as it turned out - there wasn't. The backup procedure had been failing routinely for months. The error, which had occurred during a software update, created an urgent message, which was routinely captured and stored inside a computer error log file, and had been, every day since the error began. But users stopped reading the log. It never said anything, anyway. Complacency had quietly set in, just like atherosclerosis.

This practice eventually recovered, though it took weeks of manual data entry from paper backup (you remember paper?). The point is, the initial data loss, as well as the lack

of a reliable backup, had nothing to do with mechanical breakdowns. The culprit in both cases was good old-fashioned human error.

Could it happen to you? If you say, "never - not me" you could well be falling victim to exactly the kind of complacency that creates these disasters. Here are some useful ways to prevent, or at least insulate yourself from, such a catastrophe:

First, ask your vendor how to verify your backups are actually working. If they weren't, how would you know? You might even periodically send one to your vendor and ask if it's readable (perhaps every quarter-year or so). Your backup procedure - and the verification that it's working - should not be taken for granted. You can probably replace everything else; equipment, components, application software and operating system, but, if your backup fails, you cannot replace your data without major expenditures of time and effort (i.e. money).

Second, store your backups somewhere outside your office. You are better off storing them in your office manager's home closet than in a fireproof safe next to the computer.

Third, make sure you have an adequate paper-trail. You should be storing input documents such as superbills (encounter forms), EOB's and detailed daily bank deposit records so if the unthinkable becomes reality, you can proceed with a reliable, if painful, recovery plan.

Another potential threat to the safety of your data is system security, which basically falls into three areas: physical security, login security and application-level security.

Physical security, in addition

to obviously locking the computer away from unauthorized access, must also take into consideration modems. The absolute best way to keep unwanted users (including ex-employees and hackers) from dialing into your system is to unplug modems when they are not in use. If this is not feasible, security from unauthorized access by phone line must be defended at the other two security levels. But since most offices use their modems exclusively for electronic billing and support calls from their vendor, this is usually easy to accomplish.

All business operating systems today employ login security. They require a login procedure where users must know key login commands and passwords just to get started. If not (as in single-user DOS systems), applications that perform this function can be installed for very little cost. By the way, does everybody in your office use the same login procedure and password? They shouldn't.

Next, your billing software should carry its own user ID's and passwords which take effect after the user has been accepted by the operating system. These programs require a master user to assign passwords which determine who can log in, where they can and cannot go, and what they can and cannot do (e.g. delete records).

What about computer viruses? If you don't download software from bulletin boards or make unauthorized copies from diskettes, viruses are probably not a threat.

A word about passwords: They should be somewhat cryptic (don't use names), changed periodically and not attached to workstations via little yellow Post-It notes (yes, people do this).



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*I wish mine did.*

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## PRESIDENT'S LETTER



Wm. Carl Bailey, MD  
President, 1993-1994

### The bumper sticker on the seedy looking old Volkswagen bug said "Question Authority!"

I was reminded of that sticker the other day when considering the evolution of the health care debate; i.e., early on we accepted a lot of concepts which, with time and closer scrutiny, are open to question. In some cases the news seems less worrisome; in a few cases it's worse.

We have learned a lot in the short time since the Clintons and Ira Magaziner (the White House health care adviser) shared their vision with us of what health care reform should look like. We learned, partly because a long neglected dialogue was forced upon us, and partly because we have started to ask some hard questions about assumptions on which they based their proposal. Thankfully, the health financing reform debate appears to be coming into better focus, and there's hope that genuine reform may occur. Danger still lurks, though, in making ill-advised and possibly disastrous changes in our health care delivery system. Also troubling me is the fact that a huge enterprise is being founded on possibly invalid, even self-serving assumptions and/or factoids issued by "authorities".

It appears that many have accepted that:

- there is a health care crisis;
- there are large numbers of people receiving no care;
- there is a shortage of primary care providers;
- managed health care is clearly the most cost effective and most likely to maintain quality;
- the gate-keeper is essential;

- there are 37 million uninsured;
  - health expenditures of 17% of the GDP is unsustainable;
  - 25-28% of the health care dollar is consumed by "administrative costs";
  - micro management is the only effective form of cost containment;
  - there are too many physicians;
  - nurses can perform primary care tasks as well as medical doctors, and do them more economically.
- There are numerous other examples we could cite.

Many of these statements deserve to be challenged, or at least reassessed. For example, instead of a health care crisis, I think it more appropriate to consider it a problem, albeit a severe one. "Crisis" thinking can cause hastily made counterproductive and irreversible changes in the system. These changes might have been avoided with more thoughtful consideration. Magaziner says that we are the only developed nation which doesn't have a health care entitlement system. Yet, most nations which **have** had such systems are down-sizing or abandoning them as economically unsustainable.

It's probable that this perceived crisis is based on fear more than fact, since 60-80% of Americans seem fairly pleased with their health care. Some people point to the recent economic recession as the cause for this fear since, for the first time, many white collar (management, professional and technical workers) as well as blue collar workers lost their jobs (and with their job their health insurance). It certainly doesn't help that this recession has cost us

*"... instead of a health care crisis, I think it more appropriate to consider it a problem, albeit a severe one."*



## PRESIDENT'S LETTER

*(Continued)*

six million jobs, or that one out of six jobs is now temporary.

The implication that there are many sick people dying because they can't receive care is clearly not true. Over 88% of the hospitals in this country are not-for-profit and are legally enjoined from turning away anyone. This is not to say that this manner of care is optimally cost effective, but many would take issue with describing it as a true crisis. Recently, some among us have become brave enough to challenge the premise that managed care and the gate-keeper system have really been shown to be more cost effective than other systems. Some have come to believe that under capitated systems of managed care there may be loss of quality in the attempt to meet the bottom line.

The figure (generated in 1980) of 37 million uninsured Americans was initially viewed with great alarm. Subsequently, we were relieved to learn that it wasn't quite that bad, and that many of the people attributed to that group moved in and out of it freely. Some were without insurance only for a month (the median was about six months) and the number of chronically uninsured was not so large as feared. However, a more recent update by the original author, Katherine Schwartz of Harvard, suggests that the problem has become more severe in the recession of the '90s. There are now at least 21 million long term uninsured plus 15.3 million uninsured for spells of less than one year. In any event, the hazard of being without insurance is escalating, producing greater long term consequences.

The role of primary care has been difficult to define; controversial, and at the heart of a great many discussions in planning future health care. Is "primary care" a function or does it describe a certain kind of provider? Is "primary care" the answer to improved access, cost, and quality of care? The widely respected

medical economist Eli Ginzberg feels that there is no evidence to support this position. He and others point out that the majority of sub-specialists are first trained as primary care physicians and provide a lot of primary as well as specialty care to their patients. For some, primary care may constitute 20% of their activity.

The proper proportion of generalists to specialists in the U.S. has been the subject of hot debate. Recently there have been calls to produce more generalists, and state lawmakers have been pressuring medical schools to increase the number of generalist graduates to above 50%. Some medical education experts contend that this is simply not "doable" for a wide variety of reasons, not to mention the infringement on the medical student's individual rights. Even assuming the goal were achievable, it is projected to require at least 12 years to accomplish. In Hawaii, where the population is reportedly 97% insured, the current number of generalists is reportedly 20%, compared to a higher rate in the rest of the U. S. Great Britain currently has about 40% generalists. A recent report says that Canada is training more specialists and fewer generalists. The non-physician provider's role remains in question, but certainly new collaborative functions with physicians will occur which will impact the discussion significantly.

Some analysts have raised the question of whether the consumption of 14-17% GDP by health care is, in reality, too high. Most of us probably would agree that it is, but others seriously question the premise.

As to health insurance, I question whether 25% of the health care dollar need be spent for administration, when studies indicate that the actual cost for administration is about 6%, and the balance goes to corporate profit.

Next is the question of too many physicians. Certainly considerable planning and strategy by third party payers and government is based on that assumption. It may be true, but seriously questioned when

you consider the anticipated increase in people covered by insurance. We just don't know what our true manpower requirements will be, so it is too soon to say we have too many physicians.

The question of distribution by specialty and geography is another issue. It's difficult to recruit physicians to rural areas for many reasons including pay, life-style and, I discovered in my travels, the important issue of respite. It is also very difficult to recruit physicians to the inner city. Eli Ginzberg quotes a physician ratio of 1 to 300 in New York suburbs, compared to 1 to 5000 in the inner city. The fact continues to elude the planners that physicians who devote their lives to the care of people in these areas need and deserve to make better incomes than they do. Many of the problems of physician distribution both geographically and by specialty could be eliminated by more equitable physician income distribution.

I have presented these issues not with a view of advocating for a position, but to spur more dialogue. The critical issue, as we prepare for radical changes in the way health care is delivered in this country, is to maintain an open and critical mind. The challenges and pitfalls are enormous, but we cannot stay where we are. It is incumbent upon us to make sound decisions and move ahead. There can be no sacred cows, no premise or assumption that should be blindly accepted. To "Question Authority" is not only good medical practice, but a requisite to sound socio-economic policy.

## EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney  
Executive Director  
Colorado Medical Society

In mid-January, I received a communication from James, S. Todd, MD, Executive Vice-President of the American Medical Association (AMA). This memo outlines a protocol the AMA hopes that members of the Federation will follow. It is felt that the contents of this communication are important enough to warrant a reprint in our report. Here is the text (emphasis added by CMS):

**As the health system reform debate gains momentum on Capitol Hill, the American Medical Association (AMA) recognizes that there may be policy differences among our organizations. Despite these potential differences, we believe all of our organizations are committed to finding solutions which are in the best interest of our patients while simultaneously maintaining the profession's integrity.**

**While policy differences on the details of reform are anticipated, physician organizations must take steps to keep the debate forthright and productive.** If we do not, Administration officials and Members of Congress will exploit situations where medicine is fragmented. For medicine to negotiate the best reform package for our patients and profession, we must remain as cohesive a force as possible.

The ability of medicine to successfully work together is contingent upon an environment of **mutual trust**. This trust can only be maintained if we deal openly with one another so as to avoid surprises. Moreover, while the AMA recognizes the right of organizations to publicly

state their honest differences of opinion, we believe it is inappropriate for medical organizations to denigrate the motivations of other physician groups. **Consequently, the AMA suggests adoption of an eleventh commandment which holds that thou shalt not malign the character or motives of other physician organizations.** The AMA is committed to the eleventh commandment and urges all physician organizations to adopt this philosophy as well.

In addition, we urge adherence to the following protocol designed to reduce the potential for policy and political surprises:

- (1) In stating opinions avoid attacking the character or motives of a sister organization;
- (2) If policy or strategy differences do occur and are likely to become public, notify the fellow physician organizations in advance; and
- (3) If the first two rules are not followed by an organization, then the AMA intends to contact the organization's leadership and on a case-by-case basis may also contact other Federation leaders as well as the delegates and alternates regarding such breach of the protocol.

Health system reform will likely intensify conflicts within medicine's ranks. Although we may have differences on the details of reform, it is important to remember that today's adversaries are likely to be tomorrow's allies. It also is important for medicine to emphasize the point in our communications that we are united on a number of points including among other things:

- providing universal access and

*"... it is important to remember that today's adversaries are likely to be tomorrow's allies."*

James, S. Todd, MD  
Executive Vice-President, AMA



- coverage to health care services;
- establishing a standard package of health benefits for every American citizen and legal resident of the United States;
  - guaranteeing that the quality of care under reform remains at least as high as today;
  - keeping decisions about patient care in the hands of doctors and their patients;
  - cutting the high costs of professional liability and reducing the cost of medical care by enacting meaningful professional liability reform; and
  - preserving patients' freedom to choose their own doctors, no matter what health plans they are enrolled.

With this in mind, the AMA encourages all participants in the health system reform debate to embrace this protocol. Not only will compliance with these rules minimize animosity within the house of medicine, it will help us keep the debate constructive so that the end product is in the best interest of our patients.

Fred Lewis, MD, chair of the CMS Council on Legislation, has re-constituted the Coalition of Medical Specialties to accomplish basically the same outcome as this AMA protocol. However, Dr. Lewis and I have both been a little disappointed with the results of the Coalition meetings. There have been situations in Colorado where adherence to such a protocol, as suggested by the AMA, may have proved beneficial. I would like to hear your comments on whether CMS should or should not adopt such a protocol.

Finally, I believe that the AMA should have established such a protocol long ago. Maybe some of the split in the ranks of the AMA would not have occurred over the RBRVS. Please let me know your thoughts.



### "Some thoughts from the new doc in town"

Colorado Medicine has had such an outpouring of reaction to the Special Booklet, "Some thoughts from the new doc in town", we are going to have a second printing.

The booklets will be available to those parties who wish additional copies. Rates for the booklets are as follows:

1 to 10 copies - \$1.50 each

11 to 20 copies - \$1.25 each

21 to 30 copies - \$1.10 each

Prices include postage

## Colorado Medical Society 1994 Medical Office Resource Book (Physician's Directory)

Colorado Medical Society members will have received or will soon be receiving a letter regarding the

**1994-1995 Medical Office Resource Book (Physician's Directory).**

In recent years, CMS has sent its members a response card asking "if you wish to be listed in the CMS Directory, how should that listing appear?" "Are there any changes in your listing from last year?"

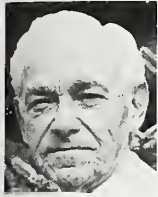
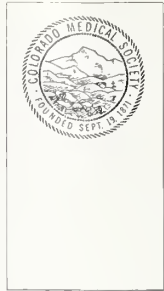
This year, however, there is certain additional information CMS needs from its members; therefore, you will receive a letter with an inquiry form to be completed and returned to CMS.

Everyone who was a member in 1993 will receive this letter; **however, receipt of the letter does not mean that you will be listed in the 1994-1995 Directory.** If you have not paid your 1994 dues prior to February 28, 1994, you will not be listed. Your name will have been dropped from the roster.

The deadline for returning this information is March 30, 1994. As of that date, CMS will not take any additional information for listings in order that our records can be updated and production of the Directory can proceed. Publication and distribution of the Directory is scheduled for June 1-15, 1994.

**Please** - look carefully at your 1993-1994 Directory and be sure your listing was correct and how you wanted it. We cannot be responsible for listings which are not outlined on the Directory Response form that we ask you to send us.

If, for any reason, you have not received this letter of inquiry by March 15, 1994, contact the CMS Membership Information Services Department at (303) 779-5455 or 1-800-654-5653.



*Frederick A. Lewis, Jr., MD  
Chair, Council on Legislation  
Colorado Medical Society*

As this is being written, the work of the 1994 Colorado legislative session has begun to accelerate. Concomitantly, your Council on Legislation has been meeting with increasing frequency - three times in the last four weeks.

For practical reasons, the Council is assuming that comprehensive health care reform is unlikely to pass at the national level. This is a necessary assumption since comprehensive national legislation would preempt most state legislation in a number of areas. If you assume that it will pass, the logical thing would be to do nothing at the state level. We are not saying that CMS opposes health care reform, we are simply assuming that it will not pass this year. In addition, there are no plans to introduce comprehensive health care reform at the state level.

Without expressing an opinion about the wisdom of Amendment One, it would be fair to say that it has simplified life for the Colorado General Assembly. It would appear that there are insufficient funds to finance many existing programs and there is almost no discretionary money available to start new programs.

There is a collection of related House Bills which comprise the health care agenda for the 1994 Colorado legislature. The first three are fairly straight forward, uncomplicated, and are sponsored by Phil Pankey, Chairman of the House HEWI Committee. All three are being supported by CMS. These three bills are:  
HB 1058 - Establishment of medical savings accounts.

HB1094 - Requires all employers to offer catastrophic health insurance.  
HB1115 - Creates a state income tax deduction for providers who furnish uncompensated care to certain patients.

There are two bills that are much more complicated but still fairly straight forward. One is HB1193 which sets up a voluntary system of purchasing cooperatives and provider networks, closely monitored by many bureaucratic rules and regulations. CMS voted to oppose this bill primarily because we felt it would add to the bureaucratic nightmare currently threatening to overwhelm the health care delivery system, would be unduly expensive, and we were unable to understand how the bill would contribute to solving any of our state's current health care problems. Our approach to the bill has generally been one of benign neglect in the hope that it will disappear without our having to alienate the sponsors.

The other bill in this group is HB 1210, a highly technical insurance bill. We felt that this bill would improve the availability of health insurance to our patients, do away with pre-existing conditions, and improve portability. We support this bill.

The remaining bill, HB1186, is a complicated "cost containment" bill with nine different sections, devoted to nine basically different issues. Our response has been to support some sections, oppose others, and suggest clarifying amendments to the remainder. It is sufficiently complex as to deserve a column unto itself.

Other bills of interest are

HB1022, the Naturopathic Health Care Practice Act. This bill would have given license to Naturopaths and allowed them to call themselves physicians. The bill was killed in the HEWI Committee.

HB1081 appears to be the first step of a two-step program which would grant independent practice to advanced practice nurses. We are watching this carefully and, thus far, have been able to amend it to our satisfaction.

If you discount, for the moment, governmental action at the federal and state levels, the remaining primary area of concern is the threat to quality medical care from overly aggressive and profit-oriented managed care organizations. In the private sector, CMS is currently engaged in an effort to mandate optional point of service benefits in all non-indemnity health insurance plans issued in Colorado. This suggestion came from the fertile brain of Joel Karlin and is consonant with current CMS policy. In addition, two resolutions will be introduced at the CMS Interim Session, by Arapahoe County which, if passed, would mandate publication of the admission and "decertification criteria for physicians panels and also provide for written notification of denial of benefits by managed health care plans.

For those of you who are attending the Interim Session in Denver, March 5 and 6, 1994, there will be an informal discussion of current legislation on Saturday afternoon, March 5, from 4:00 p.m. to 5:30 p.m. If you have questions, comments, or input, please come.



This list of Washington, D. C. FAX numbers is being reprinted with permission from the **"BULLETIN"** of the Colorado Orthopaedic Society (COS). No question, it can be a valuable resource, and we thank COS.

Here are a few Washington, D. C. facsimile (FAX) numbers of selected Congresspeople. Save this list for possible (probable is more appropriate) use.

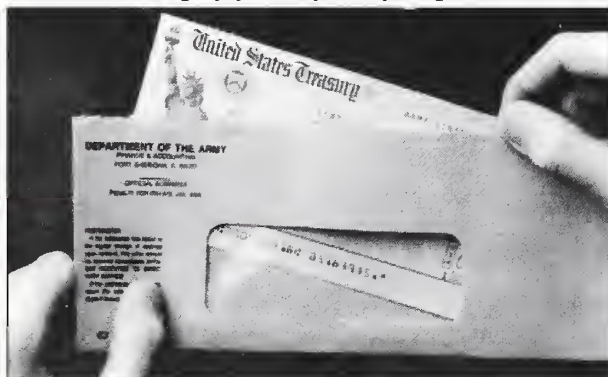
Sen. Barbara Boxer (D-CA) ----- FAX 202-224-6250  
 Sen. Bill Bradley (D-NJ) ----- FAX 202-224-8587  
 Sen. John H. Chafee (R-RI) ----- FAX 202-224-7472  
 Sen. Dennis DeConcini (D-AZ) ----- FAX 202-224-2302  
 Sen. Robert Dole (R-KS) ----- FAX 202-224-8952  
 Sen. Diane Feinstein (D-CA) ----- FAX 202-224-0656  
 Sen. Phil Gramm (R-TX) ----- FAX "Not Public"  
 Sen. Orrin G. Hatch (R-UT) ----- FAX 202-224-6331  
 Sen. Edward M. Kennedy (D-MA) ---- FAX 202-224-2417  
 Sen. Roben Kerry (D-NE) ----- FAX 202-224-2417  
 Sen. Patrick J. Leahy (D-VT) ----- FAX 202-224-3595  
 Sen. Connie Mack (R-FL) ----- FAX 202-224-8022  
 Sen. Howard Metzenbaum (D-OH) -- FAX 202-224-6519  
 Sen. George J. Mitchell (D-ME) ----- FAX "Not Public"  
 Sen. Daniel P. Moynihan (D-NY) ---- FAX 202-224-9293  
 Sen. John D. Rockefeller (D-WV) ---- FAX 202-224-7665  
 Sen. Alan K. Simpson (R-WY) ----- FAX 202-224-1315  
 Sen. Paul Wellstone (D-MN) ----- FAX 202-224-8438  
 Rep. Jim Cooper (D-TN) ----- FAX 202-225-4520

Rep. John D. Dingell (D-MI) ----- FAX 202-225-7426  
 Rep. Robert K. Dornan (R-CA) ----- FAX 202-225-3694  
 Rep. Vic Fazio (D-CA) ----- FAX 202-225-0354  
 Rep. Thomzs S. Foley (D-WA) ----- FAX 202-225-7181  
 Rep. Richard A. Gephardt (D-MO) --- FAX 202-225-7452  
 Rep. Newt Gingrich (R-GA) ----- FAX 202-225-4656  
 Rep. Fred Grandy (R-IA) ----- FAX 202-225-5796  
 Rep. Kweisi Mfume (D-MD) ----- FAX 202-225-3178  
 Rep. Earl Pomeroy (D-ND) ----- FAX 202-225-0893  
 Rep. Dan Rostenkowski (D-IL) ----- FAX 202-225-4064  
 Rep. Patricia Schroeder (D-CO) ----- FAX 202-225-5842  
 Rep. Pete Stark (D-CA ) ----- FAX "Not Public"  
 Rep. Robert S. Walker (R-PA) ----- FAX 202-225-2484  
 Rep. Henry A. Waxman (D.CA) ----- FAX 202-225-4099  
 Finally, these phone numbers you might want to keep handy. (Sorry, no fax numbers, yet.)

- President William Jefferson Clinton --- 202/456-1414
- Vice President Al Gore ----- 202/456-2326
- First Lady Hillary A.C. ----- 202/456-2957

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# 1994 Council on Legislation Part II

*Here are those members whose photos did not run last month*

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M. Ray Painter, Jr, MD



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Daniel Thatcher, MD

## Invitee



Eugene D. Jacobson, MD



Robert D. McCartney, MD

## Non-Physician Members



Peggy Fogel  
Pueblo County Medical Society



Diane Duffy Glismann  
CMS Alliance



Patti Brown  
DMS Alliance

## Ex Officio Physician Members



Wm. Carl Bailey, MD



Jonathan Feeney, MD



David C. Martz, MD



Terry Sullivan, MD



Leigh Truitt, MD



**Colorado Medical Society** is proud to be a sponsor of the

***“1994 Colorado Health Care Summit: R for Reform”***

March 14, 1994, at the Denver Performing Arts Complex, 14th at Champa Streets  
The Summit will begin at 8:30 a.m. and continue until 3:30 p.m.

The Health Care Summit will be hosted by **U.S. Representative Patricia Schroeder**

**First Lady Hillary Rodham Clinton** has been invited to give keynote remarks at 1:00 p.m. She has accepted and as this announcement is going to press, the First Lady is scheduled to be at the conference.

Colorado Medical Society announced earlier that the summit meeting would be held on February 10th, however, because of a conflict in Mrs. Clinton's schedule, the date was changed. Anyone who registered before the date was changed will be notified of the change and their registration will be honored.

No one will be admitted to the summit meeting without having registered and paid. Tickets will be sold on a first-come, first-served basis. Attached is a registration form with explicit instructions on how to register for this meeting. After you complete the form, send it with a check for \$15.00 to Columbia Institute. **No registration will be allowed by phone or by FAX.** Payment must be made with the registration.

**Tickets are available only through**

**The Columbia Institute**

**8 E Street, S.E.**

**Washington, D. C. 20003.**

**Checks must be made payable to Columbia Institute.**

Registrations will be accepted up until three days before the conference or stopped if capacity is reached before that time. If you have questions about the Summit, call Rep. Schroeder's office in Denver at 866-1230. Colorado Medical Society has no further information. As we are notified of changes we will publish this information for our members.

## REGISTRATION

ATTACH BUSINESS CARD HERE

☐ I will attend "1994 COLORADO HEALTH CARE SUMMIT: *R* for Reform" at the Buell Auditorium in the Denver Performing Arts Center on Monday, March 14, 1994. NO TELEPHONE OR FACSIMILE REGISTRATION!. My check for \$15.00 is enclosed to cover the cost of registration, luncheon and refreshment breaks. (*Please make checks payable to Columbia Institute.*)

☐ I cannot attend but am interested in receiving any information regarding any follow-up materials including the availability of audio tapes and transcripts.

Although we are all health care consumers, please mark the affiliation you also represent:

☐ provider ☐ insurer ☐ business ☐ labor ☐ government ☐ other

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Mail to: 1994 COLORADO HEALTH CARE SUMMIT:

*R* for Reform

8 E Street, S.E.

Washington, D. C. 20003

For more information,

please contact Congresswoman Schroeder's

office at (303) 866-1230 or

the Columbia Institute at (202) 547-2470.



## REGISTRATION GUIDELINES

*Please register promptly, as space is limited*

Registration is by mail only, on a first-come, first-served basis. NO TELEPHONE OR FACSIMILE REGISTRATION!. You will receive no confirmation; registration cannot be guaranteed until payment is received. Registration will be closed at 6:00 p.m. Eastern Standard Time 10 days prior to the meeting, or at capacity. Refunds and substitutions are available until 48 hours prior to the conference. Thank you.

### FEES:

Registration is available for a small fee at the Performing Arts Complex, on 15th Street and Arapahoe. For further information, call (303) 640-2862.

### HOTEL:

The official hotel of the conference is *The Executive Tower Inn* located at 1405 Curtis Street, across from the Denver Performing Arts Complex. Please mention the COLORADO HEALTH CARE SUMMIT for a special room rate of \$50.00 (plus tax). Call 1-800-525-6651 for further information.

## PREVIEW OF SPEAKERS

**CONGRESSWOMAN PATRICIA SCHROEDER**—Represents the First Congressional District of Colorado in the U. S. House of Representatives,

First elected to Congress in 1972, Congresswoman Schroeder is currently serving her 11th term in the U.S. House. She has served in House leadership as a Democratic Whip since 1976, and was appointed a Deputy Whip in 1987 and co-chair of the Democratic Caucus' Task Force on National Security in 1989. Schroeder is the Congress' most senior woman and serves on the House Armed Services Committee, the House Judiciary Committee and chairs the Select Committee on Children, Youth and Families. A champion for women's health and family issues, Congresswoman Schroeder was author of the Family and Medical Leave Act which was signed into law shortly after President Clinton took office in 1993. In addition, she has been author of legislation to provide health and pension benefits for part-time and temporary workers and cosponsored the Stark-Gradison bill to protect elderly Americans from catastrophic health care costs. Congresswoman Schroeder is a graduate of the University of Minnesota and Harvard Law School.

**HILLARY RODHAM CLINTON**—First Lady of the United States of America

Hillary Rodham Clinton not only assumed the recent responsibility of First Lady of the United States of America but also the leadership of the President's Task Force for National Health Care Reform. She is driven to provide universal access to health care at reasonable cost. In addition to these new commitments, she was deeply involved in programs for the advancement of the family, serving as founder of the Arkansas Advocates for Children and Family and chair of the Children's Defense Fund. From 1979 to 1992, Mrs. Clinton was a partner in the Rose Law Firm in Little Rock and the first chair of the American Bar Association's Commission on Women in the Legal Profession. Mrs. Clinton attended Wellesley College and received her law degree from Yale Law School.

**JOSEPH W. REINHARDT, PH.D.**—James Madison Professor of Political Economy, Woodrow Wilson School of Public and International Affairs, Princeton University.

Dr. Reinhardt has taught at Princeton University since 1968 and currently holds the James Madison Professorship in Political Economy. Professor Reinhardt's research has focused primarily on topics in health economics. In 1978, he was elected to membership in the National Academy of Medicine of the National Academy of Sciences. He has served on its Governing Council and on its Committee on the Implications of For-Profit Medicine. He earned his Ph.D. in Economics from Yale University in 1970.





*When it comes to CPR Directives,  
my doctor's a dummy. Doctors are  
supposed to know. It's the law!*

*CPR became a byword in many households, and everyone who was associated with the lifesaving procedure was familiar with the dummies used in training.*



*Today, CPR is an important aspect of physician-patient relations as the Colorado Revised Statutes now state that a physician and patient must decide mutually whether resuscitation efforts are to be administered to that patient.*

***Don't be the dummy.***  
*You, the physician, must understand CPR Directives.*

**NOTE:** Revisions to the law are currently in process. *Colorado Medicine* will publish any new information.

Colorado Medical Society (CMS) receives questions about **CPR Directives** on a daily basis. CMS is happy to answer these questions. However, CMS cannot answer questions about your patient's individual health care needs. By law, you, the physician, or your designee must respond and converse with the patient about CPR Directives relating to his/her own health circumstances.

The new state-approved CPR Directive forms were developed to create a standardized form which would be easily identifiable, state-wide, by emergency medical personnel and other health care providers. This CPR Directive is available in two formats: 1) a Patient Directive for use by those persons who are capable of making their own decisions regarding CPR, and; 2) an Authorized Agent form for use by an agent chosen to make health care decisions for someone who lacks decisional capacity to make such decisions for themselves. Each is available in both English and Spanish.

This form is transferable across facilities. However, for those who do not have the state approved form, health care facilities may choose to use their own forms or mechanisms for identifying patients who do not want to be resuscitated.

CPR Directives can be purchased from CMS by physicians and licensed or certified health care facilities only. Patients can not order them directly from CMS, but rather, must get them from their health care providers. This limitation on distribution is an attempt to ensure that patients get appropriate information

prior to deciding to execute a CPR Directive.

The state-approved CPR Directive form has three copies: The **top copy** is the original; this should be kept by the patient in a safe but easily observable place, or carried if no bracelet or necklace is worn. It is a good idea to advise the patient to inform family members of the CPR Directive and its location as well as to notify the local EMS provider agency of the Directive. The **second copy (yellow)** is to be kept by the physician in the patient's individual medical record. The **last copy (pink)** of the CPR Directive form is to be mailed by the patient with the order form for the necklace or bracelet. If the patient chooses to order a bracelet or necklace, he or she must get the order form from you, the physician, or other health care provider.

A CPR Directive can be revoked **only by the patient subject or by his or her authorized agent** by destroying the original copy and the necklace or bracelet (if purchased) or by stating that revocation is desired. The physician should be notified of this decision so that the yellow copy can be removed from the patient's medical record. **The correct use of these forms is literally a matter of life and death.** Please ensure that you, the physician, know and understand the correct procedure as set forth in Colorado Revised Statutes. If you have further questions, call the Colorado Medical Society at (303) 779-5455 for information.

# 9Health Fair

by Linda Manson, RN, MSN, ANP  
Medical Coordinator  
9Health Fair

## 9Health Fair 1993

In 1993, abnormal screening follow-up included 185 telephone calls immediately after the fair to participants whose blood chemistry analysis or screening indicated potentially life-threatening screening abnormalities. Letters discussing hyperlipidemia were sent to 34 individuals whose lipid panel results suggested extremely high cardiovascular disease risk. Approximately three months after the fair, 12,373 follow-up letters were sent to participants whose screening results identified a potential cardiovascular or cancer related screening abnormality. This letter is sent as a reminder to participants that their screening results suggested need for further evaluation with their physician, based on their **9Health Fair** findings, and 552 reported a diagnosis of cardiovascular or cancer-related diseases based on screening abnormalities identified through **9Health Fair**.

Approximately 10,000 PSAs were performed on men over the age of forty, with 8% identified outside normal range, and 18% of those respondents reporting a "malignant" diagnosis on follow-up.

## 9Health Fair 1994

- There currently are 122 sites signed up to offer free and low-cost screening throughout Colorado April 9-17.
- Two new questions have been added to the health history which address skin cancer risk.
- Participant form changes include the addition of "Wellness Goals" so the health care professional doing summary and referral will be reminded to discuss the impact of life-style on health, and assist the participant in the identification of two self-care strategies that would reduce their risk to illness and injury.
- Additions to medical protocols include the following:
  - Pulse will now be taken prior to Blood Pressure, with irregular rhythms noted.
  - Lung Function has been added as a new screening.
  - The Glaucoma screening protocol has been revised to permit the screener the option of using either the non-contact air puff tonometer, or a portable contact tonometer with disposable sterile covers on the tip.
- This program would not be possible without the 12-15,000 volunteers that participate each year. As always, physicians are needed for summary and referral and important screenings such as breast, pap smear, prostate/testicular exam, glaucoma, and skin cancer.

*In 1993, 9Health Fair screened nearly 40,000 participants at 111 separate sites statewide.*

*Editor's Note: The Colorado Medical Society has again endorsed the 9Health Fair and **Colorado Medicine** is serving as an information conduit to its members who wish to volunteer to participate in this state-wide health screening. Colorado Medical Society also has a number of physician members who serve as advisors to the 9Health Fair organization. They are Drs. Robert Sawyer, Eugene Weston and Rob Bogin.*

*There is never too many volunteer participants. Colorado Medical Society leadership encourages you to take part in this public service effort. Physicians who are able to volunteer a few hours of their time and abilities for the good of the community are asked to contact the **9Health Fair** office in Denver at 698-4455.*





## DEFINITIONS

The definition of terms in health care financing and of terms related to delivery, provision and evaluation of care. *Colorado Medicine* suggests you keep these frequent articles and definitions, even though many will change, some will disappear and new ones will appear as the health system reform unfolds.

### TERMS RELATED TO PROVIDING CARE

#### ☐ **INTEGRATED DELIVERY SYSTEM**

- A networking of primary care physicians, the hospital and a management vehicle such as a foundation, an institute, or some other third-party system manager. Thus is created an integrated delivery system which provides patient care through a network of services which includes evaluation of patient needs, clinical care and support, in-hospital stays, referral to physician specialists, and the entire recovery process. These services are then provided on the basis of a global billing by which physician and hospital services are bundled into one negotiated price for the payer.

☐ **PRIMARY CARE**-Basic or general health care which emphasizes the point when the patient first seeks assistance from the medical care system and the care of the simpler and more common illnesses. The primary care provider usually also assumes ongoing responsibility for the patient in both health maintenance and therapy of illness. It is comprehensive in the sense that it takes responsibility for the overall coordination of the care of the patient's health problems be they biological, behavioral or social. The appropriate use of consultants and community resources is an important part of effective primary care.

☐ **REFERRAL**-The practice of sending patient to another practitioner or to another program for services or consultation which the

referral source is not prepared or qualified to provide. In contrast to referral for consultation, referral for services involves a delegation of responsibility for patient care to another practitioner or program and the referring source may or may not follow up to ensure that services are received.

☐ **TERMINAL CARE**-Medical care provided as a result of an illness that because of its nature can be expected to cause the patient to die. Usually a chronic disease for which there is no known cure.

### TERMS RELATED TO EVALUATING CARE

☐ **CONCURRENT REVIEW** -Review of the medical necessity of hospital or other health facility admissions upon or within a short period following an admission and the periodic review of services provided during the course of treatment. The initial review usually assigns an appropriate length of stay to the admission (using diagnosis specific criteria) which may also be reassessed periodically. Where concurrent review is required, payment for unneeded hospitalizations or services is usually denied. Concurrent review should be contrasted with a retrospective medical audit, which is done for quality purposes and does not relate to payment, and claims review, which occurs after the hospitalization is over.

☐ **EFFECTIVE CARE or EFFECTIVENESS** - The degree to which diagnostic, preventive, therapeutic or other

action or actions achieves the intended result. Effectiveness requires a consideration of outcomes to measure. It does not require consideration of the cost of the action, although one way of comparing the effectiveness of actions with the same or similar intended results is to compare the ratios of their effectiveness to their costs.

☐ **EFFICIENT CARE or EFFICIENCY** - The relationship between the quantity of inputs or resources used in the production of medical services and the quantity of outputs produced.

☐ **PROSPECTIVE STUDY** - An inquiry planned to observe events that have not yet occurred; compare with a retrospective study which is planned to examine events which have already occurred

☐ **QUALITY ASSURANCE**-Activities and programs designed to achieve a desired degree or grade of care in a defined medical, nursing, or health care setting or program. The quality assurance program must include evaluation and educational components to identify and correct problems.

☐ **RETROSPECTIVE STUDY** - An inquiry planned to observe events that have already occurred (a case-control study is usually retrospective); compare with a prospective study which is planned to observe events that have not yet occurred.

# **"Changing our Luck"**

## **Survival with Health System Reform**

### **President-Elect's Planning Conference**

**May 13-15, 1994**  
**Sonnenalp Resort, Vail, Colorado**

Dear Colleague:

In this era of terror over the uncertainties and imposed modifications of our personal and professional lives, we find ourselves struggling to meet the challenge—and hoping our luck will change for the better. However, if "Luck" is defined as "preparation meeting opportunity", it places the responsibility on US—as individuals and as a medical society—to prepare wisely for whatever may be coming. Transitions may initially generate denial or anger, but the time must come when we move on to negotiation and resolution.

You and your spouse are cordially invited—and urged to attend—this year's annual Colorado Medical Society Planning Conference (previously known as the President-Elect's Leadership Conference) which will be held May 13-15, 1994, at the beautiful Sonnenalp Resort in Vail. The festivities will begin with dinner on Friday night and conclude at noon on Sunday.

Several changes are being explored this year:

1. The conference is being held in May instead of July to allow implementation of its recommendations prior to the Annual Meeting in September;
2. Spouses are ENCOURAGED to attend all the sessions, since our personal lives are so deeply affected by these issues;
3. All CMS leadership is urged to attend, and the conference is open to ALL CMS members, BUT total enrollment will be limited to 125 participants (so get your reservation in NOW to avoid exclusion);
4. The Friday night dinner is intended to create conviviality. Since it is FRIDAY THE THIRTEENTH and because we are focusing on LUCK this weekend, you are encouraged to display your humor and creativity and come costumed in the GOOD LUCK/BAD LUCK motif, such as the Luckiest—or Unluckiest—real or fictional person in history. (Costumed attire is optional.) Prizes will be awarded to winning individuals and couples. Joseph Michelli, Ph.D., a syndicated talk show host and consultant to physician practices, will be the upbeat speaker.

Saturday will be devoted to discussing the changes that are occurring politically and in the Health Care Industry, such as the impact of Provider Coalitions, Vertically Integrated PHOs, Capitated Care, Contractual Negotiations, Outcomes Analyses, Gatekeeper mandates, PCP-Specialist Role changes, and Governmental Control issues. We are fortunate to have Russell Coile as our leader on Saturday. Mr. Coile is a futurist specializing in the health industry and author of *Revolution* which many of you may have already read.

On Sunday Ed O'Connor, PhD, will facilitate our processing of potential responses to these issues on personal, professional, and CMS levels with the hope that new goals and methodologies will be generated. YOU will determine how far we can go in these sessions!

CMS will provide dinner for you and your spouse on Friday evening. Saturday evening is open for activities on your own. The extensive Sonnenalp breakfast buffet, including a hot entree, is included in the cost of your room (reservation form enclosed). We are most fortunate to get such reasonable rates at this first-rate resort in May!

It has been exciting to see this conference take shape. I hope that it will prove to be a landmark experience for all of us and give us direction in the complex months ahead. Please register early so you—and your spouse—can be among those who choose to CHANGE OUR LUCK!

Sincerely,

David C. Martz, MD  
President-Elect



David C. Martz, MD



# President-elect's Planning Conference

## Changing Our Luck Survival with Health System Reform May 13-15, 1994 Sonnenalp Resort, Vail, Colorado

### REGISTRATION FORM

Yes, I plan to participate in **Changing Our Luck** May 13-15 in Vail and will attend the following:

☐ Friday evening dinner

☐ Saturday/Sunday Conference

My spouse will attend:

☐ Friday evening dinner

☐ Saturday/Sunday Conference

Name \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Component Society \_\_\_\_\_

Mail your completed registration form to:  
CMS, P O Box 17550, Denver, CO 80217-0550  
Fax: (303) 771-8657 or Phone: (303) 779-5455 or (800) 654-5653

### Sonnenalp Resort of Vail

Preregistration form

Group Name: Colorado Medical Society

Name \_\_\_\_\_ Area Code and Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Number in Party \_\_\_\_\_ Arrival Date \_\_\_\_\_ Departure Date \_\_\_\_\_  
*Please Note: A deposit equal to one night's stay will be charged to your credit card. Balance is due upon checkout.*

Check one: ☐ MasterCard: ☐ Visa: ☐ Diners Club

Credit Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Cardholder's Name as it appears on the card

*Special Seminar/Conference rate will be extended to attendees for longer stays.*

Desired Accommodations:—Bavaria Haus Suites: ☐ King Bed ☐ 2 Double Beds  
\$110 per night Single or Double Occupancy —Number of Units: \_\_\_\_\_

Bavaria Haus suites all contain gas-log fireplace, large baths with soaking tub big enough for two, separate shower, heated tile floor, walk-in closet, TV, VCR, fully-stocked mini-bar, hand-carved pine Bavarian furniture, and down comforters on all of our beds.  
Rates include a full European-style breakfast in the dining room.

There will be an additional charge of \$25.00 per night for each person over 12 years of age exceeding Double occupancy.  
(Note: most suite types cannot accommodate more than 3 adults.)

Reservations received after April 22, 1994, will be taken on a space available basis only.

Cancellation Policy: In the event of cancellation 14 or more days prior to arrival, you will incur a \$50.00 per room penalty in handling charges. In the event of cancellation less than 14 days prior to arrival, you will forfeit all monies held on account.

Reservations will be taken with this form or call our reservations Department at (800) 654-8312.

**Please mail this form to:**

Sonnenalp Resort, Attn: Group Reservations, 20 Vail Road, Vail, CO 81657

# AND FROM LETTERS TO THE EDITOR



Bill Pierson, Editor

Enjoyed your treatise on Grasshopper Hill in recent issue (*Ruminations; Colorado Medicine*, Jan. '94 Vol. 91, No.1;46); however, am dismayed (not really) that you left me out. I served my internship at Pres 1945-46 with three other poor souls from Nebraska. Presbyterian was a favorite for Nebraska graduates for many years. Of course, no pictures were taken. The war was winding down. We were the only staff members under the age of 60 or were free of major disabilities, relieving us from the draft.

We lived deep in the bowels of Presbyterian and served as assistants to the likes of of Nolie Mumey and George Kent. No residents in those days. We delivered babies, did autopsies and a little of everything else between life and death. Teaching was by example and necessitated our best instincts between what we discerned as good and bad. We worked hard, on call day and night, so it was a sobering time with no time for extra-curricular activities which we made up for in later life.

I did a residency there in 1948-50 but that is another story, as is the hiatus of '46-'48. Bob and Ken Sawyer were small children in those days.

Happy to see you are still a part of the Society. Best wishes to you and others.

Ray Witham, M.D.  
8975 Lawrence Welk Drive  
Escondido, CA 92026

'Three-Fingered' Fowler were some of our good teachers. George Kent and Nolie Mumey did five cases on Monday, Wednesday and Friday, and Nolie usually finished first".



During his term, Dr. Witham campaigned hard for the reinstatement of the Colorado motorcycle helmet law. Dr. Witham stated the CMS case most eloquently, saying: "Somewhere in this question of personal freedom we are losing sight of the fact that personal behavior so often impinges on the individual freedom of many other persons". Witham then launched a campaign to initiate a referendum on the 1980 ballot to reinstate the law. This took a petition drive which lasted six months but failed. In his appeal to fellow physicians to sign the petition, Witham said: "Would you, as a physician, choose to demand to express your personal freedom, your individual right, by refusing to follow proven medical practices simply because you don't like to wear a surgical mask in the operating room? The exercise of your individual right of free choice will surely affect the lives of others . Witham contended that deaths and injuries resulting from no head protection were paid for by society, not just the motorcyclists themselves. Again this year, attempts to reinstate the helmet law failed.

Most other issues during Dr. Witham's Presidency have not changed. They are still with us today.

Bill Pierson

Those were the only pictures we found, Ray, and would certainly have included yours, had it been there. *Harry the Hopper* and the *Hopper Herald* only commenced in 1958. You were just ahead of your time to get in the newsletter. Thanks for sharing (some of) your memories.

For those of you who don't remember, or weren't around, Dr. Witham was president of Colorado Medical Society, 1979-1980. He practiced in Craig, Colorado from 1950 until his retirement when he moved to California.

Dr. Witham's inaugural address commenced by referring to "Grasshopper Hill". It was September, 1979, and Dr. Witham said: "Thirty-

four years ago, at a time when you could actually see the hill known as 'Grasshopper', I was one of four interns at Presbyterian Hospital in Denver. We all hailed from the University of Nebraska, and we were the entire complement of the house-staff. We were given room, board and fifty dollars a month, the latter being one of the attractions Presbyterian had for us because many places offered no salary".

Dr. Witham went on to say, "Chief Hendryson, Charlie Freed, Harry Hughes, Ken Sawyer and some others were still in the South Pacific starting what is now known as the M.A.S.H. Operation. At home, George Lord, Harold Henderson and

HEALTH SCIENCES LIBRARY



# Physician-Specific Data Collection

The following summary/position paper on physician-specific data was written by the CMS Data Task Force and was adopted as policy at the January Board of Director's meeting. A more detailed background paper was also prepared by the Task Force and will be available during March.

## Physician-Specific Data

The Colorado Medical Society (CMS) recognizes and supports efforts to improve the value of health care services in Colorado and to increase accountability by all health care providers. CMS encourages the effective use of provider-specific data as part of a statewide database to measure and improve quality, to manage utilization, to improve access, and to reduce the costs of medical services. These data, the process for their collection, and the ways in which they are disseminated should be developed in collaboration with providers and governed by defined goals, objectives, and principles of scientific measurement.

## Purposes of Provider-Specific Data Collection

- to provide consumers and purchasers of health care with data for decision making;
- to provide all physicians with feedback and comparative information to reinforce good practice patterns and promote quality improvement.

## Data:

- should address a clinically meaningful question and be adequate for the specific purpose;
- should be available, accurate,

- complete and valid;
- should be adjusted for patient age, gender, severity of illness, the presence of other diseases which can change the expected outcome (co-morbidity) and payer
- should reflect care that is attributable to the provider being analyzed (if there are multiple physicians, the unit of analysis may be a group - or local aggregate - such as a health plan or institution).

## Analytic Methods:

- should include evaluation of appropriate sample size and time trends;
- should ensure reporting a clinically significant difference rather than just a statistical difference (use of standards vs. normative techniques);
- should establish comparisons between providers who have similar scopes of practice, case mix, and practice location/delivery network;
- should allow physicians to participate in the process of choosing their logical aggregate for comparison.

## Reporting and Dissemination Principles:

- effective safeguards to protect against unauthorized use or disclosure should be developed;
- providers should be allowed to validate their data prior to release;
- because the science of collecting data and developing meaningful cost, process or outcome measures is relatively untested

outside of academic centers, dissemination of these data to the public and the provider communities should be handled differently.

The *public release* of such information should be staged to ensure that the data and analysis are reliable. Suggested stages are: 1) pilot studies, 2) release of data by unidentified local aggregates of physicians (such reports will minimize the problems associated with physician-specific data while still providing data which can be useful in judging care and identifying problems with the process of care), 3) release of data for identified local aggregates (listing the physicians who comprise that aggregate), 4) release of physician-specific data once data, standards of appropriate care, and methodologies are available.

Physician-specific data and comparisons should be *released to physicians as feedback* both to support quality improvement and to aid in the development of data collection, standards and methodologies that will improve the science of such measurement.

CMS favors the development of a volunteer, public, statewide coalition to develop, manage and disseminate such data. This entity should include providers, consumers, insurers, purchasers, entities with methodological expertise, and the Colorado Health Data Commission. CMS wishes to actively participate in such collaborative efforts to develop provider-specific data that will have a meaningful and lasting impact on the quality of health care in our State.

# Recent OSHA Interpretations and Compliance Information

*Regulations*

## Recent Interpretations

Since the Bloodborne Pathogen Standard became effective in March, 1992 OSHA has issued over 100 official interpretations. The following summaries of recent interpretations are taken from the Boulder-based bimonthly publication, the *Bloodborne Pathogen Update*.

**Dry Cleaning:** OSHA, in a 1993 interpretation, accepted dry cleaning as a method for decontaminating worker clothing that is used as personal protective equipment (PPE).

Paragraphs d(3)i-v of the OSHA Bloodborne Pathogen Standard require that employers launder, repair or replace personal protective equipment. OSHA has interpreted the term "launder" to include dry cleaning. According to the Centers for Disease Control and Prevention, the solvents and heat used in the dry cleaning process are sufficient to destroy bloodborne pathogens. Therefore, until there is information to the contrary, employers may use dry cleaning as an acceptable method of decontaminating employee personal protective equipment.

**Procedures Can Reduce Compliance Costs:** OSHA recently reviewed needle handling procedures at a recycling center. The interpretation may help other types of facilities reduce compliance costs.

The recycling center had a detailed procedure for sorters to follow when they found a hypodermic needle in the recycled material. Essentially, the sorters stopped the waste conveyor and notified the shift supervisor. The supervisor, in goggles and other PPE, then used tongs to remove the needle and place it in a sharps container.

Because the procedure keeps the sorters away from infectious material, OSHA stated that the sorters do not have occupational exposure and would not require training and vaccination. However, if an exposure incident were to occur among the sorters, work practices would need to be analyzed and possibly changed to reduce the exposure potential.

Of course, all supervisors who remove and dispose of the needles must be covered by all requirements of the standard.

**Compliance impact:** Safety managers can limit the number of employees with potential exposure (and thus reduce training and vaccination expenses) by using procedures to establish responsibility. The procedures should clearly define who will handle potentially contaminated material and under what circumstances the designated handlers will be notified.

## Compliance Information

The OSHA Bloodborne Pathogens Standard requires employers to use tuberculocidal disinfectants or sterilants which are registered with the EPA. Recently however, the EPA retested the registered products and found many to be ineffective when used according to label directions. Others from the list were found to have limited effectiveness.

The revocation of an ineffective product's EPA registration is a lengthy process and therefore many of these ineffective products remain on the approved list of sterilants and tuberculocides. It is likely that ineffective products will continue to be on the EPA list for quite a while.

According to some OSHA field offices, if your antimicrobial of

choice has been found ineffective you are not in compliance with the standard even if the product is still registered.

The following sterilants have been found to be ineffective, but are still registered:

- Metricide Activated Dialdehyde Solution (46781-1)
- Metricide 28 (46781-2)
- Metricide Plus 14(46781-3)
- Metricide Plus 30(46781-4)
- Wipe Out Cold Sterilizing Solution (58994-1)

The following products have been found to have problems during retesting, but are still registered:

- Alcide ABQ (45631-6)
- Alcide Exspor (45631-3)
- Cetylcode-G (3150-4)
- Clidox-S Base (8714-8)
- Bionox A (4650-6-1)

The following sterilants have been found to be effective:

- Actril Cold Sterilant (52252-7)
- Cidex Formula 7 (7978-4)
- Cidex Plus 28-Day Solution (7078-14)
- Cidex Activated Dialdehyde Solution (7078-1)
- Renalin Cold Sterilant (52252-5)
- Renalin Dialyzer Reprocessor (52252-6)
- Spor-O-Syl (675-39)
- Omnicide-14 (46851-4)

The complete EPA list of registered sterilants and tuberculocides is available from the National Pesticide Telecommunications Network (NPTN) at 800-447-6349 for \$5 or, on a floppy disk in database format from Employee Safety Systems at 800-334-1213 for \$10.

To order the *Bloodborne Pathogen Update* write to David Hustvedt, Editor, 967 Poorman Road, Boulder Colorado 80302, or call 800-334-1213.

RECENT OSHA REGULATIONS





*A monthly report of current and ongoing activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.*

The **HEALTH AFFAIRS COUNCIL** replaces several prior councils in an effort to streamline the activities of CMS. Task Forces will be used as needed to address specific topics. The agenda of this Council will come from its charge, resolutions, legislation and activities previously under the scope of other councils and committees.

### **Continuation of Committees**

The Council reviewed several committees' requests for continuation. Dr. Robert McCartney (Chair) suggested that criteria for decisions regarding continuation of committees include the following: 1) Does the committee have broad application within the membership of CMS; 2) Does it contribute to meeting the goals and focus of the society as a whole; 3) Has it been productive and well attended and is it a good use of CMS resources; and 4) Is there another medical organization in the state doing the same thing.

Based on Council discussion, the following recommendations were made:

Sunset the CMS Sports Medicine Committee as the Colorado Chapter of the American Academy of Pediatrics is capable of assuming the tasks previously covered by the Committee.

Continue the Health Care Reform Task Force under the Health Affairs Council.

Sunset the Environment Committee and allow environment issues to be addressed as needed by an ad hoc panel of experts.

Allow the Nursing Home Care

Task Force to complete its tasks as defined by RES-54-P and then be sunset. Additional issues of concern regarding nursing home care can be transferred to the new Medical Director's Association.

Allowed the Interim Data Committee to be continued as a task force, reporting to the Health Affairs Council, and be asked to develop an action plan regarding the role of CMS in data and quality of care issues.

Decided that the functions of continuing medical education, including certification of CMS CME programs, and the accreditation program be joined under one committee. The Accreditation Committee should continue and should consider expanding its membership to include representation from the previous Council on Professional Education. This combined group should report to the Health Affairs Council its action plan for these expanded activities as well as strategies to become self-supporting.

The Workers' Compensation Committee and the Non-Physician Provider Task Force continue.

The Health Affairs Council will address third party payer issues.

### **MI Grant Proposal**

Staff briefly reviewed the Robert Woods Johnson grant proposal regarding initiatives for providing care to the medically indigent. There was general interest and the Council approved staff getting further details about the grant.

### **Future meeting dates**

The Council will meet the **third**



### Thursday of each month at 6:30 pm.

The next meeting is scheduled for January 20, 1994. Staff will prepare a schedule of meetings for the next year

### Resolutions:

#### **RES 35-P: Reimbursement for Telephone Consultation.**

The Council determined that the resolution had been handled, other than ongoing monitoring. We will maintain this resolution as part of our health care reform policy.

#### **RES 36-P: Reimbursement for Paperwork Completion.**

Workers' Comp can bill and get paid for completion of mandated forms. Comment was made that additional forms should be a part of the criteria for upgrading to a higher level procedure code and that this issue could be built into the evaluation and management codes. Staff indicated that HCFA's response may be that additional reimbursement for paperwork completion is already built into the value of the code. Decided to ask staff to write letters to the Health Care Financing Administration (HCFA) and the Department of Social Services (DSS) on this. Also, if this is not already covered in AMA policy, to recommend that the AMA Delegation take a resolution to the AMA Annual Meeting.

### Legislation:

#### **HB 1186: Cost Containment**

*Recommendations to Council on Legislation:*

Should define primary care providers as those spending predominant amount of time doing activities defined as primary care

Oppose section on Techni-

cal Assessment Advisory Board

The Council reviewed the position paper developed by the Data Task Force and decided to endorse the Data Task Force report and to approve of and forward the draft amendments re: HB 1186 to the Council on Legislation.

#### **HB 1140: Managed Health Care**

- Staff indicated that this legislation incorporates portions of the CMS managed care policy. Council members stated concerns with the bill, specifically regarding the inclusion of chiropractors within the definition of basic health care services.

*Recommendation to Council on Legislation:*

Oppose the bill

#### **HB 1134: Health Care Coverage Entities**

*Recommendation to Council on Legislation:*

Comments included in the staff summary be forwarded to the COL.

#### **HB 1081: Advance Practice Nursing**

- The Council reviewed the proposed amendments.

*Recommendations to Council on Legislation:*

Clarify language and support the concept that APNs are specialists in nursing

Support amendments proposed to 1081

### Non-physician Providers

Following discussion and brief review of the consensus statements provided by the non-physician provider task force, it was noted that this paper included only those statements where there was consen-

sus among the physicians, nurses, PAs and pharmacists on the task force. Only the broad concepts are shown, as no consensus was reached about the details of implementation. Realizing that the group had gone as far as they could at this point, the task force decided not to meet again until the Spring when the Department of Regulatory Agencies releases the sunset reports on the medical and nurse practice acts.

Asked the physicians from the non-physician provider task force to develop draft policy for CMS regarding non-physician providers and to report back to HAC.

### Priorities for HAC

It was suggested that the Council dedicate some time to developing the priorities to be addressed by the Council. Members of former committees as well as the membership at large will want to know what issues and projects are replacing those addressed previously by the variety of committees which have been sunset. Regular Council meeting time will inevitably be filled with issues needing action, leaving minimal time for thoughtful consideration of where the Council wants to focus some attention.

Drs. McCartney, Ferguson, and Johnson agreed to develop a proposal regarding Council priorities.

### Tobacco Grant

Agreed to submit a letter of support to the Robert Wood Johnson Foundation for the tobacco prevention/education grant proposal.



# Medical Student Component Holds "Lunchbox" Activities

David Hutcheson-Tipton, MS I



The Colorado Medical Society's Medical Student Component (MSC) has been hosting a series of "Lunchboxes" for University of Colorado Medical Students. The latest Lunchbox featured **Miriam Reed**, Division Chief of Staff Services, Denver Police Department. She spoke on the subject "Domestic Violence: How It Affects You." Domestic violence is a reality we will all encounter in our future work as physicians, Chief Reed informed us.

When asked what to do if we know someone is battering a spouse or a child, Chief Reed said, "What do you do if you know anyone is planning any crime? You call the police."

In response to the fear that if every suspected case were reported (which is in fact Colorado Law), it would overwhelm the police, Chief Reed said that she doubted that would happen. Most things happen on a bell-shaped curve, she noted. Not all physicians would report all cases initially, and as demand for domestic violence work on the part of the police force grew, it would have to rise to the occasion.

Several times a year a guest is invited to give a presentation to the medical students. Lunch, in the form of sandwiches from Quizno's, is provided compliments of the Colo-

rado Medical Society. Speakers earlier in the year included Tom Beckett, Director, Colorado Board of Medical Examiners, and Steven Dilts, MD., with the Colorado Physicians Health Program. A spring guest will talk about health care reform in Colorado.

The Medical Student Component is quite active in the Colorado Medical Society, according to Lilly Klancar, Secretary. "We have five voting delegates. We're going to play an important role in the Interim Meeting," she stated, "we have submitted three resolutions. There will be a student member on both reference committees, the health Affairs and the Legislative Committees."





## Changes in Reportable Conditions

In 1993 the Colorado Board of Health adopted the following additions to the lists of reportable conditions (all reportable within 7 days except as indicated by asterisk [within 30 days]):

- I. Reportable by physicians and health care providers:  
Hantavirus  
Escherichia coli 0157 or 0157:-H7  
Hemolytic Uremic Syndrome in persons < 18 yrs  
\*Hemophilia A or B

- II. Reportable by laboratories:  
Hantavirus  
Escherichia coli 0157 or 0157:-H7  
CD4 counts < 500 mm<sup>3</sup> or < 29%  
Vancomycin-resistant *S. aureus*  
Vancomycin-resistant enterococci (blood, abscess)  
Penicillin-resistant *S. pneumoniae* (blood, CSF)  
\*Coagulant levels  $\leq$  30% for factor VIII or IX  
\*Chromosomal abnormalities or heritable diseases diagnosed through genetic testing in liveborn Colorado residents through 6 years of age

All of the above have an effective date of March 2, 1994 date with the exception of CD4 counts whose effective date was April 30, 1993. Reprinted from the *Colorado Disease Bulletin*, December 1993.

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## AMWA Conference

The American Medical Women's Association Region VIII Conference will be held April 15-17, 1994 in Breckenridge, Colorado at the Breckenridge Hilton Hotel. Heart of Ski Country, Last Weekend of Ski Season. Focus of this years meeting will be **Health Care Reform - Impact**. Emphasis will be placed on the impact on medical education, physicians in training and practicing physicians.

The American Medical Women's Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The American Medical Women's Association designates this continuing medical education activity for 10 credit hours in Category I of the AMA Physician's Recognition Award.

For further information contact; Elinor Christiansen, M.D. at (303) 756-4159.





### CPHP Annual Meeting

The Colorado Physician Health Program (CPHP) will hold its eighth annual meeting and physician health forum on Friday, April 22, 1994 at the Marriott West, I-70 and Exit 263. Pre registration is required.

The program will begin with a luncheon speech from Richard Irons, MD on *Evaluation and Management of Physicians with Disruptive Behavior Problems*. CPHP says that physicians who control or adversely influence health care through insensitive or disruptive words or actions often come to the attention of physician health programs and health care organizations with credentialing responsibilities. This presentation provides a paradigm for understanding and addressing these problems.

After a break, Carlton Erickson PhD and John O'Neill will talk about *Conquering Addictive Disease: Where the Scientist and Clinician Meet*. This is an interactive forum revolving around the latest scientific research on the causes and treatments for alcoholism and other addictions. It includes a progress report on major research objectives in the field and a scientific review of present approaches to prevention, intervention and treatment. The clinical, ethical, legal and economic implications of achieving research objectives will be presented.

Registration fees for the conference are \$50 (\$25 for students and residents) if received before April 1. If received after April 1, the fees are \$60 and \$30 respectively. Donations

are also being requested to support residents and students. To obtain a registration form, or for more information, call CPHP at (303) 860-0122 in the Denver area or 800-9278-0122 outside the metro area.

Lodging is available at the Marriott during the conference but advance reservations will save you money. Call 1-800-228-9290 for details.

### Balance Conference 1994: "Vision in Action"

The fourth annual Women in Medicine Balance Conference will be held August 11 through 14 in



Breckenridge, Colorado. "Vision in Action", this year's theme for the conference, exemplifies the philosophy of the keynote speaker, **Dr. Joan Borysenko**, author of *Minding the Body, Mending the Mind*.

Speaking nationally on healing in health care, both for patients and physicians, she bases her concepts on research in psychoneuroimmunology and will challenge participants to take the knowledge she shares with them and put it into effect.

In addition to Dr. Borysenko, Jan Ophoven, MD, a pediatric forensic pathologist and quality administrator, and Dr. Katherine Montgomery Hunter, a professor of medicine and author of *Doctor's Stories: the Narrative Structure of Medical Knowledge*, will speak and offer workshops which will be repeated on Friday and Saturday. For more

information on this outstanding conference, please call Ann Wilcox, Director of Physician Support Service, at 320-2401 or 1-800-535-1253.

### AMA Recognizes Dr. Batuello for Community Service



The American Medical Association has selected Stephen G. Batuello, MD, as one of 50 recipients nationwide of an award for leadership in community service by a resident physician. Dr. Batuello is a member of the CMS Board of Directors, representing the Resident Student Section.

During his college years, Dr. Batuello participated in food and clothing drives, served in food lines, and counseled troubled adolescents. After graduating from college, he organized a series of retreats to promote service oriented values among faculty and staff at Regis College and tutored illiterate adults for two years. Since entering medical school, he has organized a talent show to benefit abused children and volunteered at a clinic for the homeless.

As an honoree, Dr. Batuello will have the opportunity to attend the AMA Annual Meeting in Chicago in June.



## Rx Drug Abuse Support Group

A prescription drug abuse support group, facilitated by a certified addictions counselor is now available free of charge every Tuesday night from 7-8:30 p.m. at Aurora Behavioral Health Hospital, 1290 South Potomac, sponsored by the Colorado Prescription Drug Abuse Task Force

## Colorado's Tobacco Tax Ballot Initiative

The Fair Share for Health Committee, a coalition of organizations (including the cancer, lung and heart associations) along with hospitals, clinics, public health agencies and others, is leading the campaign for a tobacco tax ballot initiative.

**What the measure does:** The measure would increase Colorado's cigarette tax by 50¢ per pack and a similar amount on all other tobacco products. The anticipated effect of such a measure would be twofold: 1) a decrease in smoking prevalence and 2) more than \$100 million in new revenues.

The proposal earmarks the revenue in the following manner: 1) half the revenues will go toward health care for the medically indigent, 2) 30% to tobacco prevention education in schools and the community, 3) 10% to research on tobacco prevention, 4) 5% to health related education, 5) 4% to cities and counties to compensate for lost revenues due to the decrease in smoking, and 6) 1% for administrative costs for a citizen's commission

which will oversee the expenditure of dollars in the tobacco prevention education area.

**Current status:** Language is set for the ballot initiative but has been fought by the tobacco industry. The supreme court decision is due late February. Plans are being made to develop the manpower necessary to collect the 85,000 petition signatures needed to place this on the ballot in November of 1994.

**What is needed:** The Fair Share for Health Committee is trying to raise \$600,000 - enough to guarantee ballot status (some will go toward professional petition circulators, a part time staff person and part time fundraiser) and to retain voter support in the face of the ad blitz the tobacco industry will throw against the effort (Experience shows that the tobacco industry will spend more than \$5 million trying to stop the campaign. This initiative will need to air media spots toward the end of the campaign). To date, almost 1/3 of the needed amount has been raised.

Petition circulators and captains who will organize teams of five to eight circulators are necessary. A training package for petition circulators is being developed. A train the trainer meeting is scheduled for February.

For more information, call Shelly Binoeder at the American Lung Association, 388-4327 or send your name or contribution to: Fair Share for Health Committee, P.O. Box 6615, Denver, Colorado 80206.

## Assistance for Colorado Physicians treating for HIV

### *The Children's Hospital Immunodeficiency Program (CHIP)*

The Children's Hospital Immunodeficiency Program is dedicated to providing children with HIV infection family centered state-of-the-art comprehensive care in a loving, supportive manner. CHIP has a multidisciplinary team to meet the comprehensive needs of the HIV infected child and the family. The child's care is coordinated with the primary care physician, school programs, community agencies and support services.

### **Treatment Options:**

The program is affiliated with the National Institutes of Health as a research site for the Pediatric AIDS Clinical Trials Group. This affiliation assures access to the newest investigational drugs and the most recent developments in the treatment of HIV disease in children and pregnant women. Children and women are carefully evaluated for placement into treatment and protocol options.

### **Education/Community Outreach**

CHIP staff are available to respond to individuals, schools and other community agencies who may

*Continued on following page...*





have concerns about children under their care or who need information on pediatric HIV disease in general.

**Physicians who provide care** to HIV positive pediatric patients, HIV positive pregnant women or HIV positive women who are thinking about becoming pregnant **can contact CHIP** for information on treatment protocols or to enroll their patients in CHIP. All drugs and treatments related to the protocols are free. Additional care can be provided by the primary care physician or the CHIP team through private insurance or government health programs. For more information please contact Carol Salbenblatt at 861-6751.

### NTD Prevention Needs Your Help

The March of Dimes has asked for help in making physicians aware of new research in preventing Neural Tube Defects (NTDs) such as Spina Bifida and Anencephaly. While this has appeared in the medical literature, it is important for physicians to take immediate action.

Recent studies (*JAMA* 1993; 269:1257-1261) indicate that folic acid supplements can reduce the incidence of NTD's by as much as 60%. Because of this, the US Public Health Service recommends that all women of childbearing age who are capable of becoming pregnant take 0.4 mg of folic acid per day (*MMWR* 1992;41:RR-14).

Godfrey P. Oakley, Jr., MD, of the March of Dimes, says this is almost an unprecedented opportunity to reduce birth defects. He writes, "Not since the rubella

vaccine became available 30 years ago have we had a comparable opportunity for primary prevention of such common and serious birth defects." (*JAMA* 1993;269:1292-1293)

Women who have already had a child with an NTD have a greater risk for another, however, most babies with NTDs (90-95%) are born to couples who have no family history of the defect. Infants of insulin-dependent diabetic mothers have 3-10 times higher risk for NTDs.

Spina Bifida accounts for about 60% of NTDs, Anencephaly for about 35% and Encephalocele for less than 5%. Many of these conditions are correctable by surgery but this does not restore full function of malformed nerve pathways. That is why prevention is so important.

Physicians are asked to counsel their patients to consume about 0.4 mg (but not more than 1 mg) of folic acid per day if they are pregnant or capable of becoming pregnant. This is the amount contained in many multivitamins. Foods high in folic acid are green, leafy vegetables, enriched cereals, legumes and citrus fruits. These include many beans and peas, spinach, asparagus, brussels sprouts, turnip and mustard greens, broccoli, corn, okra, beets, cauliflower, orange and pineapple juice, peanuts and sunflower seeds.

For more information about prevention of NTDs and other birth defects, contact the March of Dimes Birth Defects Foundation at (914) 428-7100.

### Record Keeping and Retention: A legal minefield

Physician offices, like all businesses, accumulate records. You never even refer to many of these records. It would be so nice to just throw them away. But you never know when something will be demanded of you, by the IRS, by your auditors, by local authorities, by attorneys in a lawsuit. How do you know what to keep and for how long?

Lawyer and Certified Records Manager Donald Skupsky has written three books and some computer software to help with these problems. *Recordkeeping Requirements* details what records you have to keep and which you can — or should — destroy. *Records Retention Procedures* tells how long to keep your records and how to safely destroy them. The third book gives information on legal requirements for microfilm, computer and optical disk records. The records retention software gives you a workable system for managing your records retention and storage problems.

All of these items are published the Information Requirements Clearinghouse, which also puts out compilations of federal and state statutes regarding records. This information does not address the issues of patient medical records in any detail, but is very useful for all sorts of business records. For more information, call the Information Requirements Clearinghouse at (303) 721-7500.

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(def: chewing again what has been chewed slightly and swallowed; to REFLECT)

by **Bill Pierson**, Managing Editor

**It was 7 a.m. on a beautiful Friday morning in February.** A few of us like to get together once a month to have a light breakfast and talk over our mutual business or professional interests, problems, etc. It is quite by accident that I happen to be the oldest of the group of 10 or so: they all are well under fifty years of age, and most of them can be described as "baby-boomers".

On this morning I asked one of them, a thoughtful, motivated executive in a non-profit, about his lovely family (knowing he had an attractive and intelligent wife and two fine young sons). He said the boys were doing fine—one in high school and the other in middle school, but his wife was away for an indeterminate time. What's this? Had they separated, or what? No; his wife's mother in Chicago had an early onset of Alzheimer's Disease, and she had to be with her mother because her father simply couldn't cope totally on his own.

But, I asked, how old can her mother be? Well, she has just turned 66 and her father is the same age. They were both such active people; her father could still be if it weren't for...

And... the more obvious effects of the disorder began showing up when she was just 60.

What a tragic story, especially for those people at the height of their productivity, in their 40s and 50s. Suddenly, they have to throw down everything and care for someone they love who is, otherwise, in good physical health and will probably live many years with this totally consuming disorder.

It's happening more and more: people unable to cope with the so-called "infirmities of age" and becoming fully dependent on family or public health and welfare systems.

**That same Friday I received in the mail** a publication from the Merck Foundation entitled "*The Healthy Aging Imperative*". On the cover is this statement: "Today's 40- and 50-year-olds can extend the 'health span' to parallel the life span — and, in the process, avoid billions of dollars in health care, custodial care and lost productivity. This requires nothing less than a transformation in America's approach to aging."

This report by Mark H. Beers, M.D., FACP and Susan W. Youdovin strives to make the point (and in my case, did so - eloquently) that while we have a rapidly graying of America we still have the ability and the opportunity to help America's senior citizens in "healthy aging". If we don't heed this warning, says Dr. Beers: "if America is not to be overwhelmed by a wave of older citizens who are frail, ill, dependent on others or on institutions for care, and if the U. S. is not to be saddled with staggering debt and health-care costs that dwarf all other national priorities, then the imperative for healthy aging must be heeded."

As Dr. Beers says, Americans are living much longer, but not always substantially healthier.

The report further states "U. S. Census projections predict that in 20 years when President Clinton and the post-World War II Baby-Boom generation reach retirement, there will be an over-65 population of

*If the onset of Alzheimer's disease could be delayed by five years, it would save an estimated \$47 billion annually!\**

\*Daniel Perry, Executive Director  
Alliance for Aging Research

(Continued - following page)

HEALTH SERVICES ADMINISTRATION



some 40 million, an increase of nearly 20% over the number today". The report goes on to say that by that time, "according to census statistics, about one in five Americans will be classified as 'elderly' (over 65). Nearly eight million Americans will be over 85 and close to 500,000 will have turned 100".

**What is the conclusion?** With the exploding population comes exploding costs. Beers says everyone will feel the effects. The sick elderly will require the focus and attention of the nation's most vital and productive adults, those in their 40s and 50s, who will be called on to care for — and pay for — a dependent, ailing, but long-lived generation. Beers suggests that biomedical research on the crippling disorders that devastate the elderly and threaten to bankrupt the nation may well be the most important area of medical research at this moment. The report says we must concentrate on "squaring the curve of life

expectancy", and as a major part of our goal to help people remain healthy and active as they age, contributing their knowledge and skills to society until the end of their natural lives.

The Merck report makes a very strong case by summing up that "The United States can come closer to achieving this goal by adopting a five-part strategy:

- training in geriatrics,
- prevention,
- early detection of treatable conditions,
- slowing progression of disease, and
- discovery and development of effective new therapies to prevent, control and treat the disorders of the aging."

Beers' report says we must:

- educate the American public to take personal responsibility for the individual life-style changes that help make possible a vital and vigorous life in later years,
- ensure that physicians, nurses, other

health-care professionals and caregivers gain a deeper understanding of geriatric medicine and day-to-day care;

- "broaden our health-care focus to encompass wellness and prevention;
- direct our efforts to detecting and treating conditions that limit function;
- wherever possible, postpone the onset or slow the progression of disease; and
- support biomedical research that can continue to 'square the curve' of life expectancy — extending both years and quality of life so that people can remain vital, independent and productive throughout their natural span.

**I take the editorial prerogative** in saying this is an excellent though somewhat rattling report, and I heartily recommend it to anyone over 30 years of age. If you want a copy, I'll see that you get one somehow.

## Principles and Responsibilities

### PRINCIPLES

- A view of aging as a new stage of life and a healthy, natural process.
- An integration of geriatrics into every phase of health-care education, from physician to caregiver.
- A shift in the focus of American health-care priorities from sickness and disability to wellness and prevention. Commitment to autonomous, independent functioning for older adults through early intervention to detect treatable conditions and slow the progression of disease and disability.

- Commitment to discover and develop new medicines and technologies that prevent and treat the disorders of aging.

### RESPONSIBILITIES

- **Individual** responsibility for pursuing the behavioral and lifestyle changes that prolong life and prevent or slow the progression of disability and disease.
- **Health-care provider** responsibility for integrating understanding of geriatrics into the training of all health-care professionals and caregivers.
- **Provider and payer** responsibility for mandating measures to promote prevention and wellness and for supporting biomedical research as the most cost-effective avenue to healthy aging.
- **Community** responsibility for cultivating attitudes and options for care that respect the dignity and value of older people, for promoting public health and disease prevention measures, and for giving high priority to public and private research on the disorders of aging — for the sake of current and future generations.

### About the authors of "The Healthy Aging Imperative"

**Mark Beers, M.D., FACP**, is associate editor of *The Merck Manual* and the *Merck Manual of Geriatrics*. He received his M.D. degree from the University of Vermont and completed his residency training at The New England Medical Center in Boston and The Mount Sinai Hospital in New York. After completing a geriatric fellowship at Harvard Medical School, Dr. Beers was named assistant professor of medicine in geriatrics at UCLA, where he served as medical director of the Inpatient Geriatric Unit, Discharge Planning and the UCLA Home Care Program. He is board certified in internal medicine. He joined the Gerontological Society of America in 1982 and was elected to fellowship in 1992.

**Suson W. Youdovin** is a health-care consultant who writes extensively on health-care research and policy issues. She is based in Upper Montclair, NJ.



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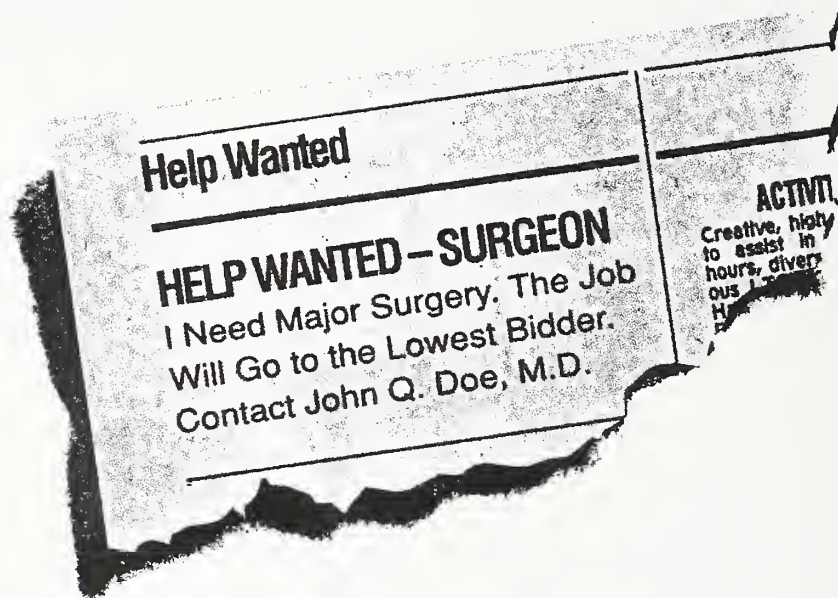
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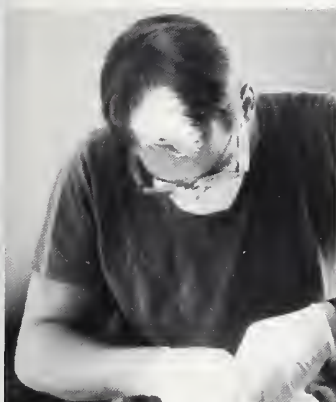


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Now Denver's Inner City residents can obtain services once available only in remote areas of Costa Rica. See page 148.

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## Consultants: An Ounce of Prevention?

Has your practice had its regular checkup lately?

A sad scenario played out in medical practices of all types and sizes is one where the doctors have been so very, very busy being doctors (an admittedly busy-making occupation), that they missed the tiny smoke smoldering somewhere in their front office. Of course it eventually flared up into a full fledged fire and quite nearly burned down the whole office.

In a 911 panic, a medical practice management consultant is called in, usually by referral from a colleague, and in he or she rushes to put out the fire and begin the requisite investigation.

As with cancer, in many cases early detection can go a long way to heading off such fires. And, like cancer, you have to know what to look for. You also have to have the right tools to help you look.

To an experienced management consultant, your computer system can be just such a tool, not only in times of crisis, but during the relative quiet of regularly scheduled periodic checkups. A consultant also offers the advantage of bringing a fresh, outsider's view of things, and this perspective can make all the difference.

But what causes these fires? Well, sometimes honest mistakes are made. Other times they result from out-and-out acts of simple dishonesty (yes, right there in your nice, clean office). Either way, these hidden problems usually produce signs or symptoms your computer system can help diagnose and treat.

Here are some of the things a consultant might check for, that may be useful in heading off problems

before they become hazardous to the health of your practice:

- 1. Lost patients.** Every transfer of records should carry a procedure code so your computer can report them on demand. Each case should be investigated to find out exactly why the patient left. Quiet problems you may never otherwise hear about, e.g. conflicts with employees, are often ferreted out this way.
- 2. Curious work hours.** Computer records may shine the light on unscrupulous employee behavior. Unexplained overtime or declined vacation time may point to embezzlement or other hanky panky ("...and she seemed like such a nice young lady"). These may be spotted on employee time printouts if either a payroll service or in-house computer payroll program is being used.
- 3. Deviations in Accounts Receivable.** Wide fluctuations from month to month or quarter to quarter in charges, payments or adjustments may also signal something is wrong. For example, if your cash flow *drops*, there should be a corresponding *rise* in your A/R. If not, you should find out why not.
- 4. Deviations in Accounts Payable.** Again, look for consistency from period to period, and have any anomalies explained to your complete satisfaction. Unexplained variations here may signal bills not being paid, or not being paid in full. Does the person in charge of paying bills also take calls from vendors? Where is the money going if not to them?

Of course there is more to look for, and a competent consultant

can usually perform a comprehensive exam on your practice in from four to eight hours. Given that the consultant's fee for that service will usually average from \$400 to \$800, a once or twice-per-year investment is probably well worth it.

Since practically anyone with a pulse can be a consultant these days, how do you locate a good one?

The best way is of course by referral. Nevertheless, you should take the same steps you would when hiring any contract labor, regardless of how highly recommended they come.

Check at least two references and eliminate consultants who have not served the medical community for at least ten years. Medical practice management is a unique discipline, and requires a detailed knowledge of procedure and history - the kind of things only experience can teach.

There is probably no need to pay more than \$150 per hour for a management consultant. Henry Kissinger you don't need.

Conversely, don't expect to pay an hourly rate of less than \$75. No experienced consultant worth his or her salt should accept less than that.

Menachem Begin is said to have remarked that "a consultant is someone who borrows your watch to tell you what time it is." Well, maybe so. But if you have a fairly complicated watch, and you have neither the time nor the ability to read it...

In other words, hire a consultant, give him or her the phone number of your computer support line, and ask lots of questions.

For more information on locating consultants, contact Edward Bowers, (303) 674-9099.

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***Colorado Medical Society***



Wm. Carl Bailey, MD  
President, 1993-1994

## Home-Folks Go To Foggy Bottom

Last week the AMA sponsored a Program in Washington D. C. entitled "Partnership in Action: Uniting for America's Health." It was intended to provide the registrants with a close-up view of the current Washington scene as it relates to health system reform, and also to demonstrate solidarity of physicians to our lawmakers. Among the speakers were Fred Barnes of the *New Republic*, and Eleanor Clift of *Newsweek* and the *McLaughlin Group*. Quotable quips included: "Al Gore ..... only a heartbeat away from the Vice-Presidency", and, "If you think health care is expensive now, wait until it's free!" Although irreverent, their candid comments were insightful and helped set the stage for the serious discussion which followed.

Speakers also included Congressmen Newt Gingrich, Jim McDermott, John Dingell, J. Roy Rowland, Jim Cooper, and Senators Phil Gramm, Bob Dole, John Chafee, Orrin Hatch, and Ted Kennedy, most of whom are readily recognized as associated with health system reform bills. Predictably, Senator Kennedy and Rep. Dingell were firm and ever optimistic in their support of the Clinton Health Plan. All the others presented differing points of view, and predictions that through White House-Congressional negotiation and compromise, the Clinton Plan would be markedly altered. One speaker humorously averred that the main difference between the Clinton Plan and Elvis was that Elvis might really be alive!

The following day, Drs. Ray Painter, Jarvis Ryalls, Tom Haygood and I visited Congressmen Wayne Allard, Dan Schaeffer, Joel Hefley, and Scott McGinnis and Sen. Hank Brown. We missed Rep. Skaggs, although I had the privilege of meeting with him last month in Broomfield. Unfortunately, we weren't able to arrange appointments to meet with Rep. Pat Schroeder and Sen Ben Nighthorse Campbell.

These visits were enjoyable. They are on top of the issues and were appreciative of our input. Of interest: there are two physicians currently in Congress and both have now offered bills. The first to do so was Dr. Jim McDermott, offering a single payer plan as exists in Canada. The American College of Surgeons, unfortunately, hasn't yet been able to counter the false impression conveyed by the media that it supported this bill. The bill, in fact, seems to have scant chance of passage. The very recently introduced bill sponsored by Dr. Roy Rowland, on the other hand, is being given serious consideration. It apparently consists of features taken from a number of the other proposals in a new combination. Rowland's bill would be much less sweeping, more incremental in its approach, and relies heavily on government supported health clinics for indigent care.

How do things really stand? It's hard to know. The consensus is that the Clinton Plan will be altered markedly in the negotiations with Congress, if it passes at all. The Clintons, in spite of declining to have

*"If you think health care is expensive now, wait until it's free! "*



any input from physicians in the early planning phases, have been quite open to dialogue in recent months, according to AMA Executive Vice-President James Todd, MD. For example, concessions to organized medicine have included adding the practice of medicine to an "area of expertise that would qualify a person to serve on the National Health Board", eliminating proposed authority of regional alliances to limit the number of fee for service plans to three, and to require a point of service option for ail plans. These compromises are intended to demonstrate some flexibility, of course, but the administration appears to hold firm to the use of alliances, employer mandates, and universal coverage, to name only a few.

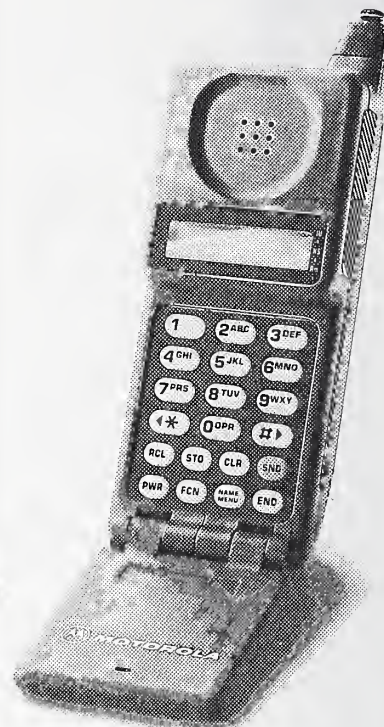
While visiting with our delegation, we drew attention to several issues. One of these is that, while all eyes have been focused on the public debate about reform, a not-so-quiet revolution has been going on in the private sector. Sweeping proposals for reform are greatly accelerating the collaboration of providers. "Merger-mania", much like a feeding frenzy, is rampant. In addition, payers and providers are channeling patients into managed care companies which are often owned by very large insurance companies. Physicians are feeling more and more out of the loop, frustrated and powerless. We pressed our conviction that physician groups can ultimately prove to be more cost-effective, innovative and creative than large for-profit corporations. We noted that in addition to the "fee-for-service" and managed care option offered by the administration, "doctor groups" are now being mentioned as a third option in recent speeches by Bill Clinton and Ira Magaziner. We strongly urged that in addition to meaningful (not token) tort reform, physicians need enabling legislation which would assist them to form doctor-owned and managed physician networks. This assistance would need to supply relief from anti-trust regulation, enable physicians to negotiate, and

possibly assist them to capitalize under a program of grants or loans. Physician networks such as we envision, competing in an open marketplace, could resolve a lot of the issues which legislators at the national and the state level are currently attempting to micro-manage and over-regulate (with all of the unintended consequences which always follow). We must restore the physician-patient relationship which is being constantly eroded by government regulations and the actions of huge for-profit corporations.

Does Congress hear us. I hope so. Every great concern of ours continues to be the fragmentation of American Medicine. I have spoken repeatedly of "Balkanization" and "endocannibalism". This fragmentation of organized medicine and its lobbyists (every group of physicians now has Washington lobbyists) is being deftly exploited by the Clinton administration as well as the congress and our commercial adversaries. We are being pitted against each other. To be heard in Congress and elsewhere, we must maintain our credibility by holding firm to important issues of patient care such as universal coverage. We also need to dissociate ourselves from the rampant commercialism which increasingly destroys the value system of Medicine. Members of Congress are very aware of the fact that some physicians enjoy very high incomes and that the behavior of some physicians has shifted significantly away from benevolence toward corporate business standards. They have been acutely sensitized to physician issues of conflict of interest and self-referral (*Iglehart, N.E.J.M. March 10, 1994*). To be heard in Congress we must put pocketbook issues aside, and retake the moral high-ground that gives meaning to the patient-physician relationship.

Getting to know your elected representatives at state and federal levels has never been as important as it is now. They respond to voters. Let them know that you vote, and that you influence the way a lot of your patients vote.

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## EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney  
Executive Director  
Colorado Medical Society

I just returned from an American Association of Medical Society Executives (AAMSE) CEO Conference in Scottsdale, Arizona. Over half of the state CEOs were present. Yes, the weather was beautiful. I had a golf lesson on a great course; however, I was not so great. The golf instructor quickly realized that his student was a stubborn, left-handed female, and a Norwegian at that. Thank goodness we both maintained a good sense of humor!

Seriously, it was a very informative meeting. Topics included national and state health system reform activities, allied health providers (AHPs), and organizational issues.

Jim Todd, MD, Executive Vice-President of the American Medical Association (AMA), was present for a good portion of the meeting and provided a national health system reform activities update. The American College of Surgeons (ACS) is scheduled to meet with Rep. Pete Stark sometime this week to talk about his single-payer bill, "*Medicare Part C*". Rumor has it that letters to the ACS are running about 50% in support of a single payer system and 50% opposed.

Dr. Todd predicted that some form of health system reform will get through Congress this year. What form it takes is anyone's guess. Look for something to happen between May and August. It will be interesting to see what stance the AMA takes. We all should continue to push what organized medicine is for, not accentuate what we are against.

The AMA Board is still grappling with employer mandates. There

are also mixed feelings about universal coverage. Does universal coverage equal a single payer system? Tough question.

Not unlike the Colorado Medical Society (CMS), the AMA is having difficulty coming to a consensus with specialty societies over some aspects of health system reform. The differences arise over funding and universal coverage. Those differences will continue, I believe, as long as money and reimbursement are at stake. Let's hope consensus can be reached on the principles.

It seems that every state is in some way involved in health system reform. None, however, is any further toward a solution than Colorado. Several states do have "Health Care Authorities". These various groups have a wide range of responsibilities, from setting global budgets to establishing general health policy for the state.

A few more states have now undertaken activities to create a statewide physician network. The forms are many, from an IPA model to an HMO model. Two states, Iowa and Oregon, have decided not to form such a network.

Many states reported on increased activities with their respective Medical Group Management Association (MGMA). I agree that we should create a closer working relationship with physician office managers. I know that there is a lot of interaction in the CMS Health Care Financing Department; however, some thought should be given to a more formal CMS/MGMA relationship.

Doctor Todd reported that the

AMA has undertaken three levels of organizational activity. 1) the AMA surveyed its employees, and has created a staff task force to look at how staff functions internally; 2) the Board of Trustees is defining the constituents of the AMA; and 3) the AMA is going forward (slowly) with the Federation Consortium.

A lot of time was spent on discussing the emerging competitors to medical societies. These competitors can be large clinics, physician-hospital organizations (PHOs), and others. Can these groups provide the same services to their physicians as CMS? Sure they can. (Look at Kaiser.) We must look at all the services and products CMS offers. We will have to find a niche to maintain the CMS membership.

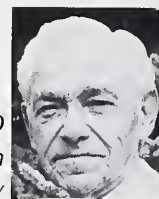
Every state is dealing with the issue of independent practice by allied health providers. All things considered, Colorado has not done too badly. The common thread was liability protection for physicians who are "collaborating" with AHPs. The AMA has prepared some excellent material on this subject.

There were times during the meeting when we all felt as if our future was truly threatened. On the other side of the coin, however, the discussions made all of us more determined and challenged.

I will be presenting several of these issues to the Executive Committee. If you have suggestions or comments on any of the items mentioned, please let me know.

Also... contact me if you would like to purchase a pair of ladies golf shoes, size 7 1/2, worn once!





Frederick A. Lewis, Jr., MD  
Chair, Council on Legislation  
Colorado Medical Society

## **DISCUSSION:** Definition of Primary Care - HB 1186 Colorado General Assembly

The current version of HB 1186 which defines primary care was drafted by the Colorado Academy of Family Practice and has passed the House of Representatives. It states:

**Legislative declaration.** (1) The General Assembly hereby finds, determines, and declares that, while many great advances in health care treatment have resulted from the knowledge, expertise, and dedication of health care professionals who have specialized in various unique health care specialties, there has been a concomitant concentration on technology and specialty health care that has resulted in a misallocation of resources away from serving the primary health care needs of the people of this state. The General Assembly further finds, determines, and declares that the lack of availability of qualified primary care health care professionals has exacerbated the problem of health care access in rural and underserved communities in this state and of educating persons in the proper and appropriate use of technologically complex and advanced specialized health care when such care is needed.

(2) The General Assembly further finds, determines, and declares that the increasing use of managed care and integrated health care provider networks and systems which frequently use health care professionals in an organizational role, commonly referred to as "gatekeepers", to direct patients into the most appropriate course of treatment requires that some basic standards be adopted to ensure that the benefits of primary care and preventative care are realized as extensively as appropriate and that the people of this state are not unduly restricted in securing specialized medical care when needed.

(3) The General Assembly further finds, determines, and declares that a review of the scopes of practice of primary care providers needs to include an evaluation of methods or means of utilizing such providers in a more flexible and efficient manner and what restrictions or barriers limit opportunities for innovative utilization of primary care providers. Such review shall consider the ability of licensed health care professionals to perform a broader range of services than currently allowed or specified in applicable licensing statutes.

**Scope and applicability of provisions.** The provisions of this article shall apply to any provider of care under Article 4, 15, or 17 of Title 26, C.R.S., and to every health care coverage plan, system, or organization which is regulated under the provisions of Article 16 of this title and which incorporates as part of its services the use of primary care health care professionals,

concepts, or resource control.

**Definitions.** As used in this article, unless the context otherwise requires:

(1) "Primary Care" or "Primary Health Care" means primary, ongoing, whole-person medical and health care services delivered by a licensed health care professional as specified in this article and which consists of at least the following services as appropriate to the need of the patient:

- (a) Preventive care and screening;
- (b) Taking of medical histories;
- (c) Physical examinations;
- (d) Basic diagnostic testing;
- (e) Diagnosis and treatment of commonly occurring physical and mental conditions;
- (f) Prescribing and managing medication therapies;
- (g) Care and treatment of minor injuries;
- (h) Education and training concerning health conditions and issues;
- (i) Minor surgical procedures;
- (j) Prenatal, obstetrical, and gynecological care;
- (k) Well-baby care;
- (l) Continuing case management of acute or chronic conditions; and
- (m) Referral to and coordination of appropriate specialty care.

(2) "Primary Health Care Provider" means a person who is licensed in this State as:

(I) A physician licensed pursuant to Article 36 of this title who provides continuous, comprehensive primary health care of patients as set

(Continued)

forth in subsection (1) of the section and who does not limit such physician's practice to one system of the human body and who:

(A) Has completed a residency program in primary health care; or

(B) Is board certified or eligible for such certification by a professional organization in primary health care;

(II) A nurse licensed pursuant to Article 38 of this title who is recognized by the State Board of Nursing as an Advanced Practice Nurse and who devotes the majority of such nurse's clinical practice to the primary health care needs of patients

(III) A physician assistant certified in accordance with the provisions of section 12-36-106 (5), C.R.S., and who devotes the majority of such physician assistant's clinical practice to the primary health care needs of patients.

(a.5) Notwithstanding the provisions of paragraph (a) of this subsection (2), a physician licensed pursuant to Article 36 of this Title who, on July 1, 1994, is actively devoting the majority of such physician's clinical practice to the primary health care needs of patients, but who has not completed a residency or is not otherwise board certified or eligible for board certification in the medical specialty specified in Subsection (1) of this section, may prior to December 31, 1994, and every six years thereafter, file a written statement with the Board of Medical Examiners that such physician is engaged in the practice of primary health care and that such care constitutes a majority of such physicians clinical practice. Upon filing such a written statement, the physician will be deemed a primary care provider.

(b) Each primary health care provider shall submit a written report on or before January 1, 1995, and every six years thereafter, pursuant to requirements established by the appropriate licensing of certifying board, disclosing such information as may be required for such licensing or

certifying board to certify that the primary health care provider has devoted and is continuing to devote a majority of such primary health care provider's clinical practice to primary health care needs of patients as required in paragraph (a) of the subsection (2).

There follows a definition of "Primary Mental Health Care" which includes a definition of a psychologist, licensed clinical social worker, psychiatric nurse practitioner or clinical practice nurse in psychiatry, psychiatrist, licensed professional counselor, marriage and family therapist. These disciplines are permitted to provide for the "diagnosis and treatment of commonly occurring emotional, behavioral, and mental disorders or the psychological aspects of physical dysfunction" to all citizens of Colorado.

#### **The Position of the Colorado Medical Society is:**

1. The definition of a "primary care provider" in HB 1186 is inaccurate and does not reflect the reality of the practice of medicine in Colorado in 1994. At the present time, probably 50% of primary care rendered by physicians in this State is provided by specialists of one kind or another. Most of this care is rendered by the various sub specialties of Internal Medicine but some is provided by surgeons, allergists, neurologists, and other specialized physicians.

2. Traditionally, organized medicine has tried to prevent the legislature (either state or federal) from limiting the practice of a specific class of physician. Currently any physician can legally do anything that he/she is qualified to do. The limitations on the details of medical practice have come through the process of hospital privileges, not through legislation. HB 1186 would reverse this policy.

3. Should CMS advocate legislation which prevents family physicians from doing major surgery, endoscopic procedures, specify that only cardiovascular surgeons can do bypass surgery, etc.

4. This definition will, inevita-

bly, be divisive in terms of pitting specialists against family physicians as adversaries in the fight for the health care dollar. Is this the proper posture for organized medicine (either CMS or CAFP)?

5. The AMA and other physician groups have wisely pointed out that the politicians will make every effort to "split" medicine in an effort to negate our voice in the Health System Reform debate. Are we going to allow this to happen?

6. The Washington State Medical Society has traveled the same road and their president, Richard Seaman, M.D. recently delivered a speech outlining their trials and tribulations at the CMS Interim Session. In drafting their Health System Reform legislation, Washington State deliberately avoided using the term "gate-keeper" since it is quite threatening to specialty physicians. Instead their legislation refers to the patient's primary physician as the "attending physician". Are we going to learn from their experience?

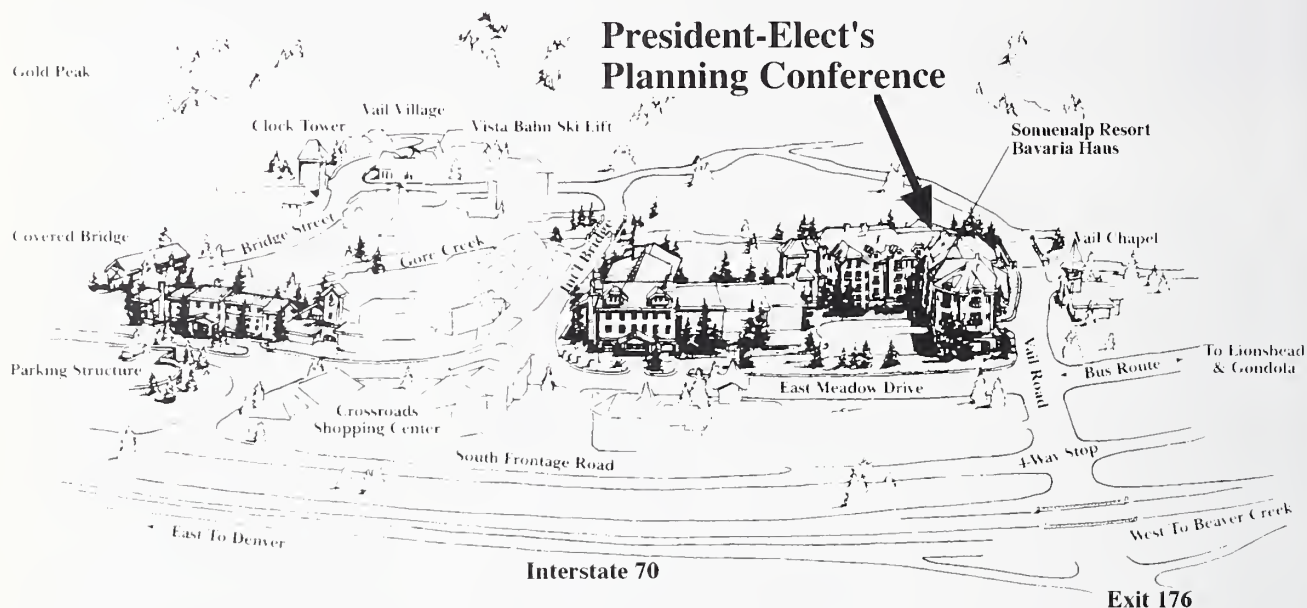
7. The Health Care Delivery System is currently in a very rapid evolutionary state at the free market level. Any attempt to "freeze" progress at this stage by passing legislation will be stifling (sp) to the free market system, anticompetitive, and will impede change.

The Colorado Medical Society is opposed to any legislation which restricts the definition of physician "primary care provider". We do not understand how such a limitation can be of benefit to either the citizens or the physicians in Colorado. In contrast, we are in favor of legislation which expands the definition physician "primary care provider". This would allow more realistic reform of the health care delivery system in Colorado.

The Colorado Medical Society advocates that the entire section of HB 1186 which defines Primary Care, Primary Care Provider, and Primary Mental Health Care Provider be deleted from the bill.



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# "Changing our Luck"

## Survival with Health System Reform

### President-Elect's Planning Conference

#### May 13-15, 1994

#### Sonnenalp Resort, Vail, Colorado

This year's Colorado Medical Society Planning Conference will be held May 13-15 at the beautiful Sonnenalp Resort in Vail.

Based on the premise that LUCK is PREPARATION MEETING OPPORTUNITY, and that physicians may benefit by moving from denial and anger into negotiation and resolution as we face the required transitions of this decade, the conference is titled "Changing our Luck." Our speakers will be Dr. Joseph Michelli, consultant to physician practices and syndicated radio talk show host; Mr. Russell Coile, a nationally known futurist specializing in medical issues; and Dr. Ed O'Connor, who will facilitate our discussions of response options.

Since the conference opens on FRIDAY THE THIRTEENTH, you and your spouse are encouraged—but not required—to costume for Friday night's banquet along GOOD LUCK/BAD LUCK themes. Options range from "Lady Luck" or a leprechaun to your version of the luckiest—or unluckiest—character of history, legend, or literature. Just be creative, get loose, and prepare yourself for an evening of fun and weekend of new insights and goals.

Registrations—limited to 125—have been flooding in since the initial announcement last month, so don't get left out by waiting too long! Send in the attached forms to Colorado Medical Society and to Sonnenalp TODAY, or you may miss the opportunity to start "CHANGING OUR LUCK" this year!!



Photo by Mike Thompson

David C. Martz, MD

## Program Schedule

### FRIDAY, MAY 13

6:00 p.m. -- 7:00 p.m. Cocktails  
 7:00 p.m. -- 8:00 p.m. Dinner  
 8:00 p.m. -- 9:00 p.m. *Changing Our Luck*  
**Joseph Michelli, PhD**

### SATURDAY, MAY 14

7:00 a.m. -- 8:00 a.m. Breakfast —on your own  
 (included with Sonnenalp rooms)  
 8:00 a.m. -- 8:05 a.m. Welcome/Introductions  
 8:05 a.m. -- 11:30 N *What's Happening Now and What's Ahead*  
**Russell Coile, Jr.**  
 11:30 a.m. 1:00 p.m. Lunch - on your own  
 1:00 p.m. -- 4:00 p.m. **Russell Coile, Jr.**

### SUNDAY, MAY 15

7:00 a.m. -- 8:30 a.m. Breakfast —on your own  
 (included with Sonnenalp rooms)  
 8:30 a.m. - 12:00 N *What Are we Going to Do About It?*  
 Based on what you heard yesterday, where do you want your practice to be in the future?  
 What stands in your way of achieving this?  
 How can CMS support you?  
**Edward O'Connor, PhD**

To arrange for **babysitting** while attending the President-elect's Planning Conference, call Lynn Debay at the Sonnenalp Resort (800-654-8312).

Our thanks to Copic Insurance Company for its generous financial support of this program.



# President-elect's Planning Conference

## Changing Our Luck Survival with Health System Reform May 13-15, 1994 Sonnenalp Resort, Vail, Colorado

### REGISTRATION FORM

Yes, I plan to participate in **Changing Our Luck** May 13-15 in Vail and will attend the following:

☐ Friday evening dinner

☐ Saturday/Sunday Conference

My spouse will attend:

☐ Friday evening dinner

☐ Saturday/Sunday Conference

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Component Society \_\_\_\_\_

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### Sonnenalp Resort of Vail

Preregistration form

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Number in Party \_\_\_\_\_ Arrival Date \_\_\_\_\_ Departure Date \_\_\_\_\_

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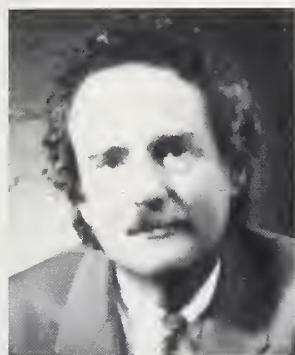
Reservations will be taken with this form or call our reservations Department at (800) 654-8312.

**Please mail this form to:**

Sonnenalp Resort, Attn: Group Reservations, 20 Vail Road, Vail, CO 81657

## Speakers for President-elect's Planning Conference

**Russell C. Coile, Jr.**



Russ Coile is a futurist specializing in the health industry. He is the president of the Health Forecasting Group, which provides market forecasts and strategic advice to a wide range of U.S. hospitals, medical organizations, and healthcare companies.

His latest book, *Revolution: The New Health Care System Takes Shape*, was mailed to over 50,000 physicians in 1993, and *The New Governance: Strategies for An Era of Health Reform* (1994) provides hospitals and trustees with strategies for managed care and national health reform.

He is the editor of the *Hospital Strategy Report* by Aspen Publishers. He is a member of the editorial advisory boards of *Modern Healthcare*, *Managed Care Outlook*, *Healthcare Competition Week*, and the *Medical Staff Strategy Report*. His columns "Leading Edge" and "21st Century Physician" appear regularly in the *Healthcare Forum Journal* and *California Medicine*.

As a California-based trends analyst, he has a "managed care" perspective on the future. In the past year he made over 100 presentations to groups including the Governance Institute, American College of Physician Executives, the Healthcare Forum, and other national healthcare organizations.

Mr. Coile holds a B.A. degree from the Johns Hopkins University and an M.B.A. in Health Services Administration from the George Washington University.

**Edward O'Connor**

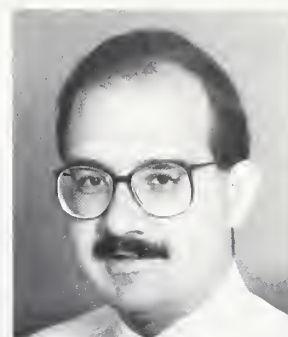


Edward J. O'Connor, PhD, is President of the Implementation Institute located in Golden, Colorado. He has 25 years of experience in human and organizational management working with corporations, nonprofit organizations, and government agencies to identify and implement strategies that improve productivity and effectiveness. He is a specialist in the areas of change management, visionary leadership, team effectiveness, and the implementation of quality programs and new technologies. His major focus is on transition management structures and methods for organizations engaged in revitalization programs.

In addition, Dr. O'Connor is a professor of management with the University of Colorado at Denver. He is an expert at generating heightened levels of organizational effectiveness. As an author of over 90 research articles, book chapters, papers, and technical documents, his work in understanding the dynamics of both individuals and corporations has yielded valuable insights for optimizing results in complex systems.

Dr. O'Connor holds an MBA from the Harvard Business School and a doctoral degree in industrial/organizational psychology from the University of Akron. He has held several managerial positions with the General Electric Company and served as president of WPRC, Inc., a financial services corporation.

**Joseph Michelli**



Dr. Joseph Michelli received his Master of Arts and Doctorate of Philosophy degrees in Clinical Psychology from the University of Southern California. He has hosted the two-hour per day call-in program entitled the Morning Magazine for the American Forum radio network. He also hosts "Wishing You Well," a weekly program on the Business Radio Network. Dr. Michelli is an adjunct faculty member in the Department of Psychology at the University of Colorado in Colorado Springs. He is Clinical Coordinator of the Capron Pain Program for the Penrose-St. Francis Healthcare System and is the Executive Director of the Center for Human Development.

*To arrange for  
babysitting while  
attending the  
President-elect's  
Planning  
Conference, call  
Lynn Debay at the  
Sonnenalp Resort  
(800-654-8312).*





## INTERIM MEETING 1994

Photos by Mike Thompson



*Dr. Richard Seaman, Past-President of the Washington State Medical Society, was well received as the keynote speaker of this year's meeting.*



*Pam Laman, President of the Colorado Medical Society Alliance presented a check from their AMA-ERF fund raising activities to Associate Dean of Students Nancy Nelson, MD, of the University of Colorado School of Medicine. The money will be used to help medical students further their education.*



*Immediate Past-President Leigh Truitt, MD was presented with a token of appreciation as he was leaving Colorado to pursue other interests. (See letter, page 147.) Looking on were (back row) Stuart Silverberg, MD, Ted Lewis, MD, David Martz, MD, (front) Wm. Carl Bailey, MD, (Dr. Truitt at podium), Sandra Maloney, and Gary VanderArk, MD.*

*Dr. Robert Brittain reminisced over twenty years of risk management in Colorado to a packed lunchtime crowd. Dr. Brittain retires from Copic's Risk Management Department this year.*





## PROCEEDINGS OF THE HOUSE OF DELEGATES INTERIM MEETING 1994

The Colorado Medical Society House of Delegates met at the Sheraton Denver Tech Center, Denver, Colorado, on March 5-6, 1994 and took the following actions:

### REFERENCE COMMITTEE ON BOARD OF DIRECTORS/CONSTITUTION & BYLAWS

**Adopted** a Resolution which defined the membership classification of half-time or less as an average of less than 20 hours per week in a calendar year in medically-related practice, e.g., direct patient care, administration, academia

**Adopted** a Resolution which amended the Accreditation Committee Bylaws to provide for an appeals board to be appointed by the Colorado Medical Society Board of Directors.

**Adopted** a Resolution which amended the Colorado Medical Society Bylaws to increase the number of members-at-large appointed to the Board of Directors from one to four.

**Adopted a Resolution which** approved that a scientific statistically valid survey of CMS members would be conducted by an organization experienced in conducting such research to determine the level of interest in forming a statewide independent provider association (IPA).

**Accepted** for filing:

Progress Report - AMA Delegation

Progress Report - Board of Directors

Progress Report - Council on Legislation

Progress Report - Council on Legislation - COMPAC

Progress Report - CMS Education & Research Foundation

Progress Report - Executive Director

Progress Report - Women in Medicine Section

Progress Report - IPA Task Force

Progress Report - Organizational Study Committee

### REFERENCE COMMITTEE ON HEALTH AFFAIRS

**Adopted** a Resolution to support efforts to increase medical student interest in primary care.

**Adopted** a Resolution that stated the Colorado Medical Society (CMS) would work diligently to pass legislation in the 1995 Colorado Legislature to mandate equitable criteria for the selection and/or termination of physicians in managed care organizations.

**Adopted** a Resolution that states the Colorado Medical Society would actively pursue an amendment to an existing Colorado statute concerning managed care companies and the methods used to confirm prior authorizations.

**Adopted** a Resolution that the Colorado Medical Society establish as policy that physicians and physician groups be accorded full and equal partner status in policy development in vertically integrated structures for health care delivery.

**Adopted** a Resolution that CMS adopt as policy and work to incorporate certain safeguards for physicians in health care plans.

**Adopted** a Resolution which stated that CMS would call for an end to pre-existing condition clauses in health insurance contracts and for community rating as the means for setting the premiums.

**Adopted** a Resolution to amend the Health System Reform Policy to state "while CMS supports moving away from an employment based health care system and increasing patient responsibility for the cost of health care services, we also promote compromise and flexibility to achieve universal coverage. This includes designing the best approach to shared responsibility of employers, individuals and government in paying for health care coverage".

**Adopted** a Resolution which calls for CMS to petition the American Medical Association (AMA) and the Health Care Financing Administration (HCFA) to consistently refer to the ideal RBRVS as the Authentic Resource Based Relative Value Scale (ARBRVS) to differentiate it from the compromised RBRVS as implemented by Medicare.

**Adopted** a Resolution directs CMS to support the AMA in its efforts to protect physicians from discrimination by health care plans.

**Adopted** a Resolution which states that the Council on Legislation will work diligently to develop legislation regarding "point of service options" in managed care plans.

**Accepted** for filing:

Progress Report - Health Affairs Council

Progress Report - Physicians Health Issues Committee

### HOUSE OF DELEGATES

**Adopted a Resolution** that the Colorado Medical Society urge the Colorado Department of Health and the Colorado Legislature to prohibit smoking in all restaurants and public places in the State of Colorado

**Adopted** a Resolution stating that any individual who is publicly representing CMS will present only established CMS policy.



# Delegate Attendance—1994 Interim Meeting

*These are the people who represented you in making the decisions on the preceding page. Please thank them for their participation.*

## Affiliation Registrant

### ARAPAHOE

Baack, Judy, MD  
Bartee, Roy M II, MD  
Barter, Jeffrey, MD  
Bartlett, Max D, MD  
Boulder, Joel C, MD  
Burks, Jack S, MD  
Capek, Richard B Jr, MD  
Gulevich, Steven J, MD  
Jolly, Susan L, MD  
Larkin, Thomas P, MD  
Levine, Mark A, MD  
Lewis, Frederick A Jr, MD  
Ozog, Mark F, MD  
Scanlon, Charlotte D, MD  
Stecher, Karl Jr, MD  
Steffen, Grant E, MD  
Thulin, Barbara W, MD  
Vanderark, Gary D, MD  
VanScoy, Sarah B, MD  
Vernon, Walter B, MD

### AURORA-ADAMS COUNTY

Clark, Sallie B, MD  
Gottula, Roderic D, MD  
Heaton, Angeline D, MD  
Heaton, Carl E, MD  
Manguso, Robert L, MD  
Rich, John D, MD  
Sherman, Morton E, MD  
Sundland, Barry R, MD  
Visconti, Paul B, MD  
Vitanza, Joanne M, MD

### BOULDER COUNTY

Benson, Alan E, MD  
Bolles, Frank P, MD  
Bolles, Gene E, MD  
Carr, Alfred N, MD  
Curtis, William S, MD  
Farrington, John F, MD  
Kelley, Severance B, MD  
Mooney, Herbert S Jr, MD  
Rubright, Mark W, MD  
Rupp, Gerald R, MD  
Steinbaugh, John R, MD

VanHook, Charles J, MD  
Vickland, James R, MD

### CLEAR CREEK VALLEY

Brundige, Richard L, MD  
Cedars, Chester M, MD  
Doig, William L, MD  
Doyle, Herman E, MD  
Furman, Joseph, MD  
Henbest, Philip M, DO  
Laubach, Sherri J, MD  
Mains, Charles W, MD  
Martin, Darnell L, MD  
Mozia, Nelson I, MD  
Netz, Howard E, MD  
Oppenheim, Walter H, MD  
Parry, Lynn, MD  
Sadler, Dean L, MD  
Santoro, John A Jr, MD  
Tarkanian, Malcolm A, MD  
Tegtmeier, Ronald E, MD  
Weingart, James H, MD  
Wolf, Robert J, MD  
Yocum, Harold A, MD

### CO-WY GASTROENTEROLOGICAL SOC.

Goff, John S, MD

### COLO SOC. OF INTERNAL MEDICINE

Claassen, David W, MD

### COLO. SOCIETY OF CLINICAL PATHOLOGISTS

Stienmier, Richard H, MD

### Colorado Psychiatric Society

Guerra, Frank, MD

### CURECANTI

Hopple, Lynwood M, MD

### DENVER

Anneberg, A Lee, MD  
Ballinger, Carter M, MD  
Bogin, Robert M, MD  
Bumgarner, Frank E Jr, MD  
Butterfield, D G, MD  
Campbell, William A III, MD  
Carson, Bonita S, MD  
Cochrane, David R, MD  
Cook, William R, MD  
Foust, Glenn T III, MD

Gottesfeld, Ray L, MD  
 Jacobs, Mary Jo, MD  
 Jacobson, Eugene D, MD  
 Kail, Thomas J, MD  
 Kandel, George E, MD  
 Karel, James L, MD  
 Kelble, David L, MD  
 Kinzie, Jeannie J, MD  
 Major, Francis J, MD  
 McCartney, Robert D, MD  
 Nelson, Nancy E, MD  
 Owens, J Cuthbert, MD  
 Rainer, W Gerald, MD  
 Regan, James R, MD  
 Rhodes, Edward A, MD  
 Rumack, Carol M, MD  
 Safford, H R III, MD  
 Sawyer, Robert B, MD  
 Sbarbaro, John A, MD  
 Schemmel, Janet E, MD  
 Schramm, Victor L Jr, MD  
 Stigler, Del, MD  
 Walker, Louise D Converse, MD  
 Woodard, W Donald, MD

#### **EL PASO COUNTY**

Ballard, Phillip W, MD  
 Barry, Francis J, MD  
 Cole, Norman G Jr, MD  
 Crawford, Lewis A, MD  
 Emeis, William E, MD  
 Feinsod, Fred M, MD

Gifford, Marilyn J, MD  
 LaVoo, John W, MD  
 Lloyd, William E, MD  
 Nielsen, Peter G, MD  
 Pollard, Joseph S Jr, MD  
 Rubinow, Sidney D, DO  
 Sherman, John L, MD  
 Silver, Gordon S, MD  
 Simerville, James J, MD

#### **FREMONT COUNTY**

Buglewicz, John V, MD  
 Gamache, Peter J, MD

#### **LARIMER COUNTY**

Bush, James F, MD  
 Chase, Jerry A, MD  
 Ezell, William W, MD  
 Giansiracusa, Richard F, MD  
 Hammond, Richard O, MD  
 Honea, Bertrand N III, MD

#### **LAS ANIMAS COUNTY**

McFarland, Douglas M, MD

#### **MEDICAL STUDENT COMPONENT**

Bonacci, Paul D  
 Johnson, Brian L  
 Klancar, Lillian  
 Odom, John A Jr  
 Wepman, Carolyn J

#### **MESA COUNTY**

Alpha, Sigma, MD  
 Doran, John H, DO  
 Golter, Lee B, MD

Klein, M G, MD  
 Linnemeyer, Robert F, MD  
 Magraw, Bronwen J, MD  
 Sadler, Theodore R Jr, MD

#### **MONTEZUMA COUNTY**

Fury, Dianna L, MD

#### **MORGAN COUNTY**

Thompson, Patrick L, MD

#### **MT. SOPRIS COUNTY**

Painter, M Ray Jr, MD

#### **OTERO COUNTY**

Berg, Mary J, MD

#### **PUEBLO COUNTY**

Alessi, John R, DO  
 Drake, Robert L, MD  
 Gaide, Thomas K, MD  
 Luebke, Donald C, MD  
 Morgan, Alethia E, MD  
 Presti, Blair C, MD  
 Ryals, Jarvis D, MD  
 Snyder, Charles E, MD  
 Wilz, William P, MD  
 Woods, Phillip H, DO

#### **SAN LUIS VALLEY**

Brownrigg, Richard L, MD  
 Culp, Raymond M, MD

#### **WELD COUNTY**

Bradley, Robert C, MD  
 Flower, Thomas J, DO  
 Kemme, Douglas J, MD  
 Kiser, Rick E, MD

## **HIGHLIGHTS OF BOARD OF DIRECTORS MEETING March 4, 1994**

- Copic:** Dr. Howard announced that Copic had made their first attempt to enter the hospital business and that they had two more targets in mind.
- CMSA:** Ms. Pam Laman, President, announced that Legislative Day on February 28th was quite successful. She expressed her gratitude to the CMS staff for their assistance.
- AMA Delegation:** Dr. Quinn reported that the AMA Delegation had submitted several reports from the AMA Interim Meeting as well as resolutions based on information received at the AMA Interim to the CMS Interim Meeting.
- UCHSC:** Dr. Krugman, Dean, School of Medicine, was present and reported on activities of the School of Medicine. Dr. Krugman stated that Dr. Bailey and he were forming a Task Force to study ways to generate interest in faculty members to become active in CMS.
- Board of Directors:** The Board approved the actions of the Council on Legislation in their decision to support the smoking initiative, the Respiratory Care Practice Act, the use of motorcycle helmets, standards of medical treatment for occupational injuries and to oppose the Naturopathic Health Care Practice Act.
- The Board approved a request from the IPA Task Force to initiate an application to the Robert Wood Johnson Foundation to obtain funding for a means tested fee schedule study. The Board approved a change in the CMS Investment Policy which will allow a minimal portion of CMS invested funds to be placed in stocks under a money manager's direction. The Board referred the recommendations of the Medical Practice Act Task Force regarding amendments to the Act to the House of Delegates for discussion and approval.





# Rocky Mountain State Hosts Health Care Summit

Michael P. Thompson  
Assistant Managing Editor



*Colorado Governor Roy Romer and First District Representative Patricia Schroeder flanked First Lady Hillary Rodham Clinton as she explained the President's health insurance reform ideas to the packed house.*

There are many prominent figures in health system reform, and most of them were represented in Denver, March 14. Colorado's First District Representative Patricia Schroeder hosted a health care summit to bring together infor-

mation and players involved in the health care debate.

The best known was Hillary Rodham Clinton, First Lady of the United States and the President's health care "czar". Rep. Schroeder expressed optimism that President and Mrs. Clinton would be able to accomplish something that, according to her, stymied Presidents Roosevelt, Truman, Johnson, Carter and others, namely to institute an equitable, universal system of providing health care in the United States.

Mrs. Clinton began her remarks by characterizing the current status of the health care debate, "Thank goodness we have gotten beyond the rather false argument about 'is there or isn't there a crisis'. The folks who tried to peddle that have backed off, and they now recognize, along with the rest of us, that there *is* a crisis. It may not have entered into everyone's life, but it is a *potential* crisis for all of us, because we all live with the kind of insecurity that comes when you do not guarantee insurance to every citizen."

The First Lady said the President's plan is built on five basic principles:

- *Guaranteed private insurance with comprehensive benefits for every American.*
- "What the President wants is guaranteed private insurance with comprehensive benefits for every American."
- *Elimination of insurance practices such as pre-existing condition limitations, lifetime limits on benefits, experience rating, "cherry-picking", and age discrimination.*

"We need to eliminate the insurance practices in the marketplace today that do drive up the cost for some people, and discriminate against individuals and groups of individuals." "We want to eliminate pre-existing conditions. Everybody should be insurable. Nobody should be eliminated from insurance because they have been sick at one time."

- *Guaranteed choice of physician and health plan including a point of service option.*

"What is happening today, is that more and more Americans are being deprived of choice. How many of you in this hall today get your insurance as most of us do, through the work place and have been told some time in the past several years that your employer has picked a different plan?"

- *Preservation of Medicare, with the addition of prescription drugs and long term care option.*

"The fourth point I want to make is that the President's approach preserves Medicare."

Photos by Gil Maestas, II

***"[T]here is a crisis. It may not have entered into everyone's life, but it is a potential crisis for all of us, because we all live with the kind of insecurity that comes when you do not guarantee insurance to every citizen."***

- ***Guaranteed employer based/shared responsibility insurance***

"The fifth point has to do with how we finance health care and where we actually get our guaranteed private insurance."

In order to provide universal coverage yet maintain a mix of employer financing and individual contributions, Mrs. Clinton said there must be a cap on small business contributions and subsidies for low wage workers. She claimed that this approach would lower costs to businesses who presently insure their employees in both the long term and the short term and would not lead to net job loss.

Although Mrs. Clinton used terms related to health care, her explanations related almost solely to health care *financing*. For instance, she maintained that the status quo is not stable, it is deteriorating, "We have had in the past year, an increase in the uninsured. We have had in the past year, an increase in premium rates for small businesses and families. We have had in the past year, increasing pressure on our public programs like Medicare and Medicaid."

She referred to an earlier remark by Governor Roy Romer, "If you believe, as the Governor said, that everyone should have health coverage in America, and I believe that, I hope we're beyond that debate. Any reform that does not include universal, guaranteed health care for every American will be vetoed by this President, because if we don't have guaranteed health coverage for everybody, we have not reformed our health care system."

Given the President's commitment to universal coverage, she said, there are only three ways to reform health care in America:

1. Single payer system
2. Mandatory individual health insurance
3. Employer based, shared responsibility insurance

Denver Mayor Wellington Webb welcomed the participants to the Health Care Summit, saying of Hillary Clinton, "if there's one message we want her to leave Denver with, and take back to Washington, DC, it is that we support her and that we want her to stay the course." While Mayor Webb said that everyone has access to health care, through emergency rooms and indigent programs, if nowhere else, he advocated reforming the entire delivery system to eliminate situations such as one in which a young mother chooses to be on public assistance because she cannot get health insurance if she takes a job.

Representative Schroeder noted that everyone has access to health care now, but said that reform would provide a much more uniform system in which everyone could have the same kind of insurance with only one form to fill out and a credit card-like device which would simplify the process of obtaining benefits. She decried a system which discriminates against people based on factors beyond their control, such as genetics, but advocated more choices for people based on factors they could control, such as smoking and financial risk.

Rep. Schroeder also mentioned

she was proud that the Colorado National Guard was the first to take advantage of an amendment she introduced a couple of years ago which allowed National Guard units, including health care units, to train in the U.S. and thus give health services to indigent and homeless people here, rather than only in places such as Costa Rica. (See story and pictures elsewhere in this issue.)

Uwe Reinhardt, PhD of Princeton University was the featured speaker in the morning sessions of the program. He advocated "putting our mouth where our money is". In other words, he said, the way we currently spend money in health care, "tells something about our soul". Dr. Reinhardt said, "In the public debate which we are going to have and are having now, instead of promising to put our future money where our generous mouth is today, let's start today, first of all, by putting our mouth where our quite modest money is today." This examination of our social ethics in a practical context enables us to see what we really believe is important. If we do not like what that reveals, we can change it, because we recognize it.



*Colorado Medical Society members, such as Ted Lewis, MD, Vice Speaker of the House of Delegates, were among those attending the presentation.*





## LETTERS

Colorado Medicine  
welcomes input from its  
readers. Please address  
your correspondence to:  
Editor, Colorado  
Medicine, PO Box 17550,  
Denver, CO 80217-0550.

As a recent book (*J'Accuse!*) noted, the real crisis in this country's medical care lies in how to pay for it. It does not concern the quality of that care, which is among the best if not the best in this world. Current estimates put the total cost of that care in 1994 at about *one trillion dollars*. Congress, our president and voters might think about some things it involves.

1) Government sources recently estimated the bureaucracies involved in our medical care complex today consume about 20% of that cost, or about *200 billion dollars*. These bureaucracies live on, thrive on, regulations and paper. Today's health care complex is drowning in both and it keeps getting worse.

2) Our medical malpractice and liability climate consumes about another 15% of that total cost, or *150 billion dollars*. This involves more than law suits that actually end up in court. it involves all actions taken to minimize law suits by all health professionals, pharmaceutical companies, salesmen and druggists, and by all the manufacturers who supply the thousands of things needed to support health care activities. It increases the costs of all equipment, consumable supplies, medicines, employees, communications, buildings and other facilities involved in our health care.

3) *In short, things that do not prevent, diagnose or treat a single patient will consume about 350 billion of that one trillion dollars.* That is over a third of the whole cost.

4) How would our president

reduce that cost? He suggests two major actions (among numerous lesser ones) that would yield on result.

Suggestion #1: He would add to present health insurance costs that cover about 210 million of us, additional insurance to cover the about 40 million others who have no health insurance. If scaled up from what it now costs to insure 210 million of us, that should add another 190 billion dollars to present health care costs.

Suggestion #2: To control that he would add another federal bureaucracy to oversee all the others that already consume about 200 billions of our health care dollars.

The result: He promises this: Insuring another 40 million people plus adding another giant bureaucracy to existing ones would cost far less than instead of far more than one trillion dollars. Sure the tooth fairy is real too.

5) *Why not move from fantasy to reality and begin reducing those 350 billion dollars that do not even help to treat a single patient? Is that not where real and huge potential savings lie in this health care "crisis"?* To any reader who concurs: Why not send a copy of this letter to your Representative?

H.M. Frost, M.D.

*Dr. Frost is an Orthopedic Surgeon who belongs to the Pueblo County and Colorado Medical Societies.*



March 10, 1994

Wm. Carl Bailey, MD, President,  
Sandi Maloney, Executive Director,  
and CMS Staff,  
Board of Directors  
Colorado Medical Society

Dear Bill, Sandi, CMS Staff, and  
Members of the Board of Directors:

I would like to thank you and all  
of the members of the Colorado  
Medical Society for the opportunities  
you have given me over the past  
three years. This has been a wonder-  
ful time in my life in which I learned  
a great deal and, in addition, was  
able to serve you to the best of my  
abilities.

I would also like to thank you for  
the gift of the beautiful etching. (*Ed.*  
*see page 140*) I will hang this in my  
office wherever I go so that I can  
think back on wonderful memories  
of Colorado and specifically the  
Colorado Medical Society.

As you will recall from the  
movie, *Animal House*, there comes a  
time when it seems appropriate to go  
on a "road trip". I have every  
intention to return to Colorado but  
hope to gain some knowledge about  
the insurance industry and how  
medicine is practiced in different  
parts of the country.

During my travels about the  
country in my job search, I learned  
two things. First of all, Colorado is a  
wonderful place in which to live and  
practice medicine. The climate, the  
attitudes and the people cannot be  
surpassed. Second, the quality of  
medicine in Colorado is exceptional.  
The physicians here truly care about

their patients and have the training  
and desire to provide them with the  
best of health care.

I will be back. I will miss you my  
good friends in the Colorado Medi-  
cal Society. Keep up the good work  
and the practice of medicine will  
continue to be the most rewarding  
profession.

Thanks again for everything.

Yours truly,

Leigh Truitt, MD



Leigh Truitt, MD  
President, Colorado Medical Society  
1992-1993

## Director of Medical Affairs

Poudre Valley Hospital, a regional refer-  
ral center in northern Colorado, seeks a  
physician to join its top management  
team as Director of Medical Affairs.

The Director of Medical Affairs will  
serve as a communication liaison  
between the hospital's medical staff,  
administration, and board of directors.  
You'll join other administrators in help-  
ing the hospital achieve its mission and  
goals by participating in such activities  
as strategic planning, budgeting, pro-  
gram development, clinical practice  
guidelines, continuous quality improve-  
ment, risk management, utilization  
management, advocacy, and communi-  
cations, among others.

To be considered for this position, you  
must be a board certified physician,  
currently licensed (or eligible) to prac-  
tice in the state of Colorado, with at  
least five years' clinical practice

experience. Preference will be extend-  
ed to individuals with experience in  
hospital administration or other profes-  
sional leadership and CQI.

PVH serves parts of three states with a  
comprehensive program of primary  
and tertiary services. Eight percent of  
the 230-member medical staff is board  
certified.

Fort Collins is a university community  
located just one hour north of Denver,  
at the foot of the Rocky Mountains. It  
is highly regarded for its recreation  
opportunities and quality of life.

To be considered for this position,  
please send your resume to Diane H.  
Malcolm, Associate Administrator of  
Human Resources and Development  
Services, Poudre Valley Hospital, 1024  
S. Lemay Ave., Ft. Collins, CO 80524.  
Equal Opportunity Employer.



POUDRE VALLEY HOSPITAL



# COLORADO ARMY NATIONAL GUARD MISSION: Denver's inner city

Story and photos by Gil Maestas, II



147th Combat Support Hospital commencing operations at 24th and Lawrence streets in Denver. The unit's 75 Army National Guard personnel served the inner-city neighborhood for 14 days with typical medical and dental exams and treatment.

**For the first time in Colorado** history a cooperative pilot program between the Colorado Department of Health and the Department of Military Affairs provided military medical training while also benefiting the local communities.

In the past, National Guard Units in Colorado have performed military exercises in Central and South America. These exercises are referred to as a MEDRETE or *Medical Readiness Training Exercise*. A MEDRETE typically involves three areas: medical, veterinary and dental.

The question most frequently asked was; Why can't these exercises be performed here at home in the U. S. for our citizen's benefit?

Last year Congress passed a pilot program authorizing Governors to direct the National Guard to perform these types of operations within the state boundaries. Representative Pat Schroeder, (D) lauded the program at the 1994 Colorado Health Care Summit. Any state that wishes to participate may do so, however Congressional intent is to provide military personnel experience with field medical procedures and equipment, while also providing needed health services to federally designated underserved and underprivileged civilians. In 1993, five States including Tennessee, Arkansas, Maryland, and Georgia participated in the program.

All National Guard operations must be done in conjunction with a

Civilian Health Organization (CHO). Patient certification, referral, and follow-up; as well as providing most non-military supplies and equipment, are the responsibility of the CHO. This service was provided by the Colorado Department of Health as well as the Stout Street Clinic, a volunteer medical clinic for indigent care.



What makes Colorado unique in the United States in this training exercise is that a major field setting was utilized, as opposed to working out of buildings. Rather than screening, the Colorado unit performed

diagnosis and treatment.

Thus: **GuardCare Colorado** was born. For the 147th Combat Support Hospital of the Colorado Army National Guard, under the direction of Captain Joseph R. Rice, this project was the first mission where a two-week period was spent in a major field setting in the inner-city. This MASH type unit was located at 24th and Lawrence streets in Denver. The Combat Support Hospital was basically a non-emergency clinic offering standard types of care that can be found in physician's offices and clinics. Diagnosis and treatment of minor injuries and illnesses, dental care, eye care, immunization, TB screening, cardiovascular screening and dietary counseling all were included.

Response from the community was very positive. Captain Rice said, "The first day we moved into the area people were curious about what was going on. The second day we made flyers inviting the neighborhood to an open house... the reception has been great. We have not heard a single negative comment."

As of March 16th the unit had treated over 700 patients. The Unit will conduct clinics in Colorado through September of 1994.

**GuardCare Colorado** was approved or endorsed by the Governor, Attorney General, Departments of Health and Military Affairs, The Colorado Medical Society and the Colorado Coalition for the Homeless.



by Dick Martley, CLU, ChFC  
Copic Agency  
(303) 930-0483.

## Annuities

There are two phases of annuities. The first phase is what interests nearly everyone. In this phase, the policy **accumulates** cash value from your deposits and the interest earnings credited by the insurance companies.

## Deferred Annuities

Deferred annuities are tax deferred with outstanding safety. These are no-load policies (meaning your full deposit is placed into your account) which grow in value without current taxation. Currently credited interest is from 4.5% to 7%.

There are two types of deferred annuities. **Fixed** deferred annuities are general obligations of the insurance company. Your policy is guaranteed by the company as to your principal (your deposits) plus a minimum interest rate for life, typically 3%. **Variable** deferred annuities allow you to direct the investment yourself. You bear the risk of market value, not the company. The only guarantee in a variable annuity is a death benefit which at least equals your total deposits. Both Fixed and Variable annuities pay your beneficiary the full account value exceeding your total deposits at your death.

## Immediate Annuities

This is the second (or pay out) phase of annuities. You may surrender your deferred annuity for a lump sum payment or installments. The annuity contract may pay you for a lifetime

or for a limited number of years, like 20 years with the lottery. Both *fixed* income and *variable* income Immediate Annuities are available with many options.

## Taxes

All interest is taxable as you receive payments from your annuity. If you deducted your premiums from your income tax calculation, you also pay income tax on your total payments. The IRS also requires a surtax of 10% on payments received before you are 59 1/2 (not applicable for death or disability) unless you select an immediate annuity or have the company systematically pay your account over many years. Please call me for an explanation or for proposals and check the chart at right for an example of how the tax savings can help your annuity grow.

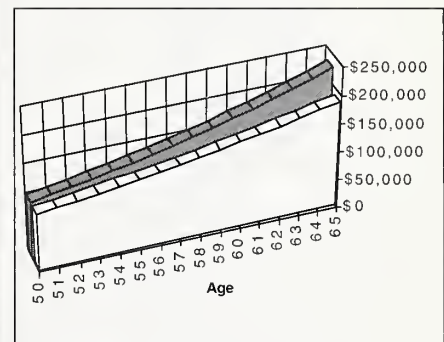
## Going, Going, Gone!

The long term guaranteed level premium term life insurance will soon be a thing of the past. The National Association of Insurance Commissioners has issued Guideline XXX with a proposed 1/1/95 execution date.

This guideline puts new reserve requirements on term life policies with more than a five year premium rate guarantee. Companies will have to charge higher premiums because of the strain on life company surplus. Some insurance companies will not offer term life policies with premiums guaranteed beyond five years.

**ACTION:** Apply now for a 15 or 20 year guaranteed premium policy if you desire term life insurance.

Tax Deferred Annuity vs. Taxable CD



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# Code of Cooperation continues to serve well after more than 40 years

by Michael P. Thompson  
Assistant Managing Editor

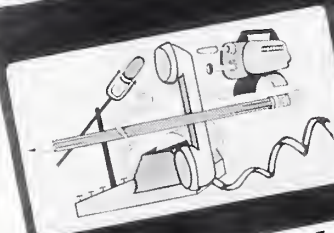
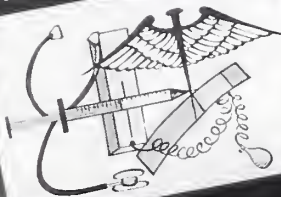
## Code of Cooperation Guidelines circa 1975

Colorado Broadcasters Association  
Colorado Department of Health  
Colorado Department of Institutions  
Colorado Hospital Association  
Colorado Medical Society  
Colorado Press Association  
Denver General Hospital  
Denver Medical Society  
Denver Post  
Metro Denver Hospital Council  
Rocky Mountain News  
University of Colorado Medical Center

## Colorado Code of Cooperation

Guidelines for:  
• Medical Profession  
• Hospitals  
• News Media

## public information guidelines for colorado hospitals, physicians and news media



## Code of Cooperation: 1985

Forty-six years ago this month, Colorado made history in medical-press relations. On April 16, 1948, the Colorado State Medical Society officially adopted the "Code of Cooperation" guidelines for relations and information exchange between the medical profession, hospitals, and the news media. The announcement in the *Rocky Mountain Medical Journal* for June, 1948 mentioned that "The action is heralded as unique in the United States by national publications in the press and radio fields, which credit Colorado with another 'first' in medical public relations."

The guidelines were the brain-child of Harvey Sethman, then Executive Director of the Society, among others. Mr. Sethman was a newspaperman before being hired in 1929 as the state medical society's first non-physician director. He recognized the need, even then, for guidelines to keep relations cordial and information flowing between physicians and media personnel. He also recognized that these things will not happen automatically.

Dr. John S. Bouslog, then President of the Society, is credited with bringing together representatives of the competing interests for the common good. Though there were intense rivalries between individual media outlets and between the two fields of radio and newspapers, these representatives presented draft after draft to the group until the final form was agreed upon.

There are still times when reporters think physicians or hospitals are stonewalling them, trying to

hide something or cover for someone. They may be frustrated by hospital policies which prevent them from covering a story in the manner they think best. Medical people, on the other hand, wonder just why these nosy reporters want to know about things they usually consider part of the confidential physician-patient relationship. They can be afraid to say something which will be used against them in the press or hesitant to appear on camera, not knowing how their remarks will be received.

The Code of Cooperation was designed to help in these situations, drawing the line between confidentiality and the people's right to know, at least in general terms. It also helps everyone to learn, as did its formulators, that "the other fellow is human too". The originators of the Code considered it an expansion on the Golden Rule, explaining how it can be applied between the "medical profession and the public's editors and reporters".

The guidelines were revised in 1955, 1975, 1980 and 1989 in an attempt to keep them current and useful. Representatives of the Colorado Medical Society, the Colorado Hospital Association, the Colorado Press Association and the Colorado Broadcasters Association, in conjunction with representatives of individual media outlets, come together yearly to discuss interpretations and applications of the Code and to build the bridges that will enable health care providers and the press to live together amicably and adequately serve their individual constituencies.



Health care legislation has always been a major focus of the Colorado Medical Society Alliance. Physicians' spouses try to familiarize themselves with bills directly related to health care and to establish a working relationship with our legislators. We understand the stresses of patient care, the never-ending government regulations and the mountains of paper work with which you are faced. We try to work with you and with local, state and national government officials to influence legislation that will eliminate unnecessary regulations, decrease the paper work and the stresses, project a better image of organized medicine in the community and allow you to do what you do best; take the best possible care of your patients.

In order to further educate our members, our annual Legislative day was held February 28th. The morning speaker was Representative Scott McInnis. Sixty Alliance members and physicians heard Representative McInnis explain his four health care panels and their conclusions about the Clinton Health Care Plan. These panels, with broad representation from the community, including providers and consumers, seemed to feel that government should not be running health care in our country and that the plan is not fiscally sound.

After this informative talk, we went to the State Capitol, where we were briefed on current state bills by Sandi Maloney, Executive Director of the Colorado Medical Society, Lorraine Koehn, Director of the Department of Government Relations and State Representative Pat

Sullivan, MD.

Thirty six legislators joined us for lunch to discuss their stands on bills and to listen to our concerns. It is important for these representatives and senators who often know little about medicine and medical care to hear from those closely associated with medicine. We felt that we were listened to and that we were able to establish good rapport with our legislators.

We appreciate the assistance given to us by the CMS staff and planning Legislative Day and the attendance of Dr. Bill Bailey, Dr. Fred Lewis, Sandi Maloney, Lorraine Koehn, Suzanne Hamilton and members of the Legislative Council at this event.

Our commitment to legislative affairs and rapport with our legislators means that you have a ready and will group to help you deal quickly and efficiently with legislators regarding health care legislation.



*Pam Laman, President  
Colorado Medical Society Alliance*



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# A nother open letter

W. George Shanks, M.D.  
Grand Junction, CO

*Overall, we provide a quality product that we should be proud of. Let's concentrate on what we can do and guide the others ... in what they should do.*



W. George Shanks, M.D.

Dr. Shanks is a General Surgeon who practices in Grand Junction, Colorado. He is a member of the CMS Board of Directors.

Dr. Shanks received his Degree in Medicine from Temple University in Philadelphia, and interned in Denver. He also did his residency at St. Joseph's Hospital in Denver. He has been a member of Colorado Medical Society for over 19 years and is an active member of Mesa County Medical Society.

In December, 1993, I wrote about the role of physicians in the delivery of health care. Although a few of you expressed support of these ideas, the vast majority seem indifferent or at least resigned to Mrs. Clinton's concept that we should have no voice in this matter.

I remain concerned that organized medicine is still taking a reactive position, waiting for a proposal from the politicians and then shooting it down. This puts us, in the eyes of the public, in the role of spoiler rather than that of patients' advocates. I am particularly concerned with our support of several concepts that don't make much sense to me:

- The first is lack of universal access. In reality, access has been all too easy. A call to 911 would result in a patient being picked up at the door and delivered to the best facility in the world, and woe be to the physician who tried to interfere. The main purpose of managed care organizations and gatekeepers is to block this access.
- Equating lack of insurance to lack of care is a concept I will not accept. The care is being delivered and there is nothing inherently wrong with individual responsibility to pay for services when needed. Of the 37 million who lack insurance, I suspect that less than 10% actually need health care services and none is denied care.
- Preventive care is touted as the panacea of the future. Other than childhood immunizations and Pap smears, there is no preventive care that couldn't be accomplished by practicing moderation and personal hygiene. The down side of this concept is the realization that if the patient follows our advice and still becomes sick, we will be held responsible.

- If the time, energy and resources that have been expended on administering and assuring quality care had been directed into delivery of care, there probably would be no "crisis".

The federal government has been both the hero and the villain in this real-life drama. With the enactment of Medicare, not only was care of the elderly, poor and disabled financed, but also the education and research that has made us what we are today.

The problem is that we did our job too well. We have conquered sickness and disease, our patients are living healthier and more productive lives and, therefore, the costs are going up. Yesterday's government made a promise years ago; We, the taxpayers, have difficulty in honoring this commitment. Mandates for increasing care without adequate financing have got to stop. Cost shifting needs to be explained and reversed.

Overall, we provide a quality product that we should be proud of. Let's concentrate on what we can do and guide the others, government, insurance companies, hospitals and patients, in what they should do.

I fear that the threat of government control is driving us to seek shelter in managed care organizations. I suspect that in the long run this will be a lot more detrimental to ourselves and our patients, as **we** will be the ones **rationing** health care. Let's not be so willing to sell our dignity to a few entrepreneurs and bean counters.

The Colorado Medical Society is supporting a statewide IPA and I think we should actively encourage its implementation.

The COMMITTEE ON PROFESSIONAL EDUCATION AND ACCREDITATION, chaired by Dr. Roy Stahlgren, met February 3, 1994 and approved re-accreditation for the following institutions: Mercy Medical Center, Denver; Colorado Mental Health Institute at Pueblo; Avista Hospital, Louisville; and Poudre Valley Hospital, Fort Collins. These institutions have been re-surveyed by the Colorado Medical Society Program of Accreditation and awarded full accreditation as sponsors of continuing medical education for physicians.

CMS accreditation seeks to assure both physicians and the public that continuing medical education activities sponsored by accredited organizations meet the high standards of the Essentials for Accreditation as specified by CMS.

Congratulations to all four institutions.

#### WOMEN IN MEDICINE: INVENTING OUR FUTURE

The upcoming Fourth Annual National Conference for women physicians, entitled "Women in Medicine: Vision in Action", will be held Thursday, August 11 through Sunday, August 14, 1994. This continuing medical education conference is sponsored by Rose Medical Center in Denver and is approved by the ACCME for a total of 14.5 credit hours of CME.

At our third annual conference, "Women in Medicine: Inventing our Future", one hundred fifty women from twenty-six states attended. This year's conference will be held at the Hilton Hotel in Breckenridge, Colorado, which has room for up to 250 attendees.

We are very excited to have the following speakers booked for this event:

- Joan Borysenko, PhD, author of *Minding the Body, Mending the Mind* and *Fire in the Soul*, and a Harvard-trained psychologist, speaks nationally on healing in health care. As the keynote speaker, she will present the powerful address entitled, *Healing the healer*. Her philosophy: when we give to others out of compassion and balance, we increase well-being; when we give out of duty, because we "should", we burn out. This will be a focal point of the address. Dr. Borysenko will help participants learn the tools for healing, and joyful helping.

- Jan Ophoven, MD, is the physician quality manager at St. Paul Children's Hospital, St. Paul, Minnesota, and a teacher of medical quality improvement, management and data analysis tools. Dr. Ophoven helps participants practice skill building for working with competitive, technically oriented, interventionist peers in an effort to shift physician culture to flexibility, cooperation and support, serving the mutual goals of excellent patient care, teaching and research.

- Katherine Montgomery Hunter, PhD, is a professor of medicine and the author of *Doctor's Stories: The Narrative Structure of Medical Knowledge*. She emphasizes the human side and value of case stories, and feels doctors learn medicine by constructing and presenting cases, enabling them to find "The Story Within the Case".

Again this year, we have a dynamic program of workshops. Our keynote speakers will present

*A monthly report of current and ongoing activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.*

workshops along with their major presentations.

This three day program is designed to enjoin a large female physician audience with a wide variety of specialties, and to provide physicians with information and tools to build a successful medical practice and a rewarding personal and family life.

If you would like more conference information or a brochure, please call Ann Wilcox, Physician Support Services at (303) 320-2401, or 1-800-525-1253. We hope you will join us in the majestic Rocky Mountains for this remarkable conference!





## DEFINITIONS

The definition of terms in health care financing and of terms related to delivery, provision and evaluation of care. *Colorado Medicine* suggests you keep these frequent articles and definitions, even though many will change, some will disappear and new ones will appear as the health system reform unfolds.

### Health Care Definitions...

#### TERMS RELATED TO PROVIDING CARE

☐ **PRIMARY CARE**-Basic or general health care which emphasizes the point when the patient first seeks assistance from the medical care system and the care of the simpler and more common illnesses. The primary care provider usually also assumes ongoing responsibility for the patient in both health maintenance and therapy of illness. It is comprehensive in the sense that it takes responsibility for the overall coordination of the care of the patient's health problems be they biological, behavioral or social. The appropriate use of consultants and community resources is an important part of effective primary care.

☐ **REFERRAL**-The practice of sending patient to another practitioner or to another program for services or consultation which the referral source is not prepared or qualified to provide. In contrast to referral for consultation, referral for services involves a delegation of responsibility for patient care to another practitioner or program and the referring source may or may not follow up to ensure that services are received.

☐ **TERMINAL CARE**-Medical care provided as a result of an illness that because of its nature can be expected to cause the patient to die. Usually a chronic disease for which there is no known cure.

#### TERMS RELATED TO EVALUATING CARE

☐ **OUTCOME MEASURE**-a measure of the *quality* of medical care in which the standard of judgment is the attainment of a specified end result, or outcome. The outcome of medical care is measured with such parameters as improved *health*, lowered *mortality* and *morbidity*, and improvement in abnormal states (such as elevated blood pressure). Any disease has a "natural history" which medical care seeks to alter. To measure *effectiveness* of a particular medical action in altering a disease's natural history is to carry out an outcome study or measure.

☐ **QUALITY ASSURANCE**-Activities and programs designed to achieve a desired degree or grade of care in a defined medical, nursing, or health care setting or program. The quality assurance program must include evaluation and educational components to identify and correct problems.

☐ **UTILIZATION REVIEW**-Evaluation of the necessity, appropriateness and efficiency of the use of medical services, procedures and facilities. In a hospital this includes review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices, both on a concurrent and retrospective basis. Utilization review can be done by a utilization review committee, peer review organization (PRO), peer review group, or public agency.



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- This certificate and the car rental pursuant to it are subject to Alamo's conditions at the time of rental. Minimum age for rental is 21. All renters must have a valid driver's license.
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*For information about community activities, contact Betsy Fox at 355-8845. For information about membership in the Society, contact Carol Willoughby at 693-6127.*

### **Colorado Ob/Gyn Society Wins Wyeth Award**

For the second time in three years, the Colorado Ob/Gyn Society has won the prestigious Wyeth Award, designating the Colorado Section as the most outstanding in the U.S. This award is for outstanding activities in 1993, and is a result of the Teen Pregnancy Prevention Awareness Campaign begun in April, 1993. As a result of this effort, 150,000 teen pregnancy prevention posters have been distributed statewide. The Society is developing a Speakers Bureau to give presentations to teachers, students, parents, and community groups concerning all aspects of teen pregnancy prevention, and the Society continues distribution of the posters. The Wyeth Award will be presented at the National American college of Obstetricians/Gynecologists meeting in May. The award comes with a check for \$2,500 which will be donated back to the Teen Pregnancy Prevention Campaign.

### **Jack Thorne Wins Community Service Award**

Jack Thorne is the recipient of a new award created by the President of the American College of Obstetricians and Gynecologists, the President's Community Service Award. In his capacity as the first Chair of the Teen health Education Committee, Jack took a stand on behalf of the Society

to do something about teen pregnancy in Colorado. After two years of planning and creation of the teen pregnancy prevention posters, Teen Pregnancy Prevention Awareness Week was launched in April, 1993. Efforts included a Governor's Proclamation, bus signs, billboards, a press conference covered on the front page of the Rocky Mountain News, and a Symposium attended by 300 people. The award includes a check for \$500, which will be donated to the Teen Pregnancy Prevention Campaign.

### **Legislative Dinner to be held April 19**

The Annual Legislative Dinner will be held April 19 at the St. Francis Conference Center on the Auraria Campus. This year, Senator Claire Traylor will be honored for her many years of distinguished service on behalf of Colorado citizens with the "Women's Health Care Advocate of the Year" award.

### **Legislative Breakfast to be held April 7**

The Annual Legislative Breakfast will be held at the Capitol Building on April 7. The Breakfast will begin at 7:30 am. This is always a unique opportunity to chat with legislators, and to get to know staff members as well.

For information about community activities, contact Betsy Fox at 355-8845. For information about membership in the Society, contact Carol Willoughby at 693-6127.



## Interference with IMEs

A case has come to our attention in which an attorney interfered with the process of an Independent Medical Examination (IME), causing the physician to refuse to carry out the examination. Identifying details have been removed from the story.

**Background:** While documents provided to us in this case do not note it specifically, IMEs are often with Workers' Compensation cases, No-Fault Insurance cases and other insurance matters, when there is a question on a patient's disability or impairment. They are considered a form of utilization review and in general, a "second opinion."

**The facts:** Attorney A requested an independent medical examination of a patient. The patient's attorney, B, agreed to the examination, but placed several stipulations on his client's participation. The physician, an orthopedic surgeon, was scheduled to do the examination, but refused when informed of the stipulations.

The patient's attorney demanded that his client be "accompanied by a relative, nurse, friend or some one from this office for monitoring purposes. A tape and/or video recorder may be on during the examination." He also stipulated that his client not be required to complete any medical history questionnaires, sign any forms whatsoever, or undergo any "painful tests or examinations, e.g. electromyogram, without prior written approval of my office."

If X-Rays were needed, Attorney B required a previous review of X-Rays already taken so not to needlessly expose his client to unnecessary radiation. He also stated that his client would only be "examined and not interrogated" and specifically prohibited "multiple doctors in the exam room" although the Workers' Compensation law on IMEs allows for another physician to be present. He also requested a copy of the IME's report, which is in keeping with applicable laws.

The physician had begun to review the patient's medical records when informed of these stipulations. He objected to several of them and noted that a proper medical history is "an important part of the IME." He noted that "painful tests" could be construed to include anything Attorney B or the patient wanted it to and would be so subjective a requirement as to be impossible to fulfill prior to doing any orthopedic examination.

The physician also objected to the prohibition of "interrogation". He said, "Interrogation of a patient, the question and answer period, is a vital part of an orthopedic examination. This is cogent whether it is an IME or whether it is an orthopedic examination that I carry out on a daily basis with my patients."

The physician appealed to Colorado Medical Society policy in regard to persons present at an IME and the use of monitoring devices such as tape and video recorders, requested by Attorney B. At the Interim Meeting in 1993, the CMS House of Delegates passed a resolution supporting the integrity of the

IME, by assuring that a *physician* can determine who will be present during an examination. The policy states that, "If the physician's integrity is abridged by judicial action, the physician has the right to refuse to perform the examination."

The physician concluded that a proper examination was impossible under the circumstances, saying, "I cannot render an independent medical examination in an honest and competent manner with these restrictions imposed upon me." He therefore notified the attorney that he could not carry out the examination under these conditions. The physician informed the CMS of the incident and recommended to Attorney A that he investigate the possibility of having the bar association grievance committee take a look also.

## Rohrer Named Public Health Leadership Institute Scholar



**Hugh Rohrer, M.D., M.P.H.**, executive director of Tri-County Health Department, has been chosen by the national Public Health Leadership Institute as a 1994

Scholar. Rohrer joins an elite group of 62 of the top public health leaders in the U.S. who will participate in the year-long program.

"Being chosen an Institute Scholar is a tremendous honor. This





will be an opportunity to do more work on addressing the complex health challenges facing the metro Denver area, Colorado and the nation," Rohrer said.

The Purpose of the Institute is to strengthen America's public health system by providing city, county and state public health officials a forum to discuss contemporary public health issues. Scholars communicate from their home offices via a computer network, complete self-study activities and attend one week of class in California.

Begun in July 1991, the Institute is led by the U.S. Centers for Disease Control and Prevention and the Western Consortium for Public Health which represents the University of California at Berkeley, the University of California at Los Angeles and San Diego State University's schools of public health.

Rohrer is a member of the Board of Directors for the Colorado Department of Health and the national Association of County Health Officials. Tri-County Health is the local health agency for Adams, Arapahoe and Douglas counties located in metro Denver, Colorado.

### Smoking Cessation Guidelines Available

The AMA recently released new smoking cessation guidelines that provide physicians a step-by-step approach to implement a "stop smoking" program for patients. The guidelines have been endorsed by the National Cancer Institute, the Centers for Disease Control and the

American Society of Addiction Medicine. To obtain a free copy, call Lynn Livingston at CMS, 779-5455 or 1-800-654-5653 or write to P.O. Box 17550, Denver, Colorado 80217-0550.

### Two Organizations Develop New HIV Early Intervention Guidelines

The U.S. Department of Health and Human Services and the American Medical Association have each recently developed HIV early intervention guidelines. Both organizations have identified "front line" primary care providers as the group most likely to benefit from their guidelines and accordingly, have disseminated them to primary care physicians across the nation.

The HSS guidelines, entitled, *Early Evaluation and Management of HIV Infection*, were developed by a private-sector panel of physicians, dentists, nurses, social workers, physician assistants, and a man and a woman living with HIV. These guidelines include special recommendations for women, adolescents and children. Copies may be obtained free of charge, through a joint effort with the Centers for Disease Control and Prevention, by calling 1-800/342-2437. Persons with telephone-equipped facsimile can get the quick reference guide, consumer booklets, and an overview of the guidelines by calling AHCPR Instant Fax (301/594-2800) 24 hours a day.

The more condensed AMA guidelines entitled, *HIV Early*

*Intervention*, are also available free of charge. Call Lynn Livingston at CMS, (303)779-5455 or 1-800-654-5653 to obtain a copy.

### Colorado Children's Immunizations Coalition Immunization Update

In October 1993, the US Public Health Service revised the childhood immunization schedule. The major changes were: 1) the first dose of MMR (measles, mumps and rubella vaccine) can be administered at twelve to fifteen months of age; 2) the booster dose of Hib (Haemophilus influenza type b vaccine) can be administered routinely at twelve to fifteen months of age; 3) the third dose of OPV (oral polio vaccine) should be routinely administered at six months of age; and 4) the fourth dose of whole cell DTP can be given as early as 12 months provided the interval between DTP dose three and four is no less than 6 months. **Please note: DTaP cannot be given before 15 months of age and it may only be used for the fourth and fifth doses.** These changes will allow for much more flexibility in the immunization schedule that providers use in their practice.

Richard Hoffman, M.D., from the Colorado Department of Health, has reminded us that the Colorado Board of Health requires that the first dose of MMR be administered at  $\geq$  12 months of age. This regulation is closely enforced by schools through-



out the state. If a child has been immunized at less than 365 days of age, they are not considered adequately immunized and will not be allowed to enter school. Therefore, the **Department of Health recommends that physicians and health care providers instruct their office staff to not schedule children for their one year check-up until on or after the child's first birthday.**

The Standards of Practice Subcommittee of the Colorado Children's Immunization Coalition has been working to educate providers in the state about vaccine schedules and appropriate contraindications to vaccine delivery. Charts explaining both the schedule and contraindications of vaccines have been mailed to all primary care providers throughout the state. If you have not received one, or would like additional copies, please contact Lori Stonehocker Quick, RN, MSN, at the Colorado Department of Health, (303)692-2794.

In addition to the charts that have been developed and distributed, Lori has been traveling around the state to give inservices to providers and clinic support staff about immunization schedules, contraindications, and the intricacies of childhood vaccine delivery. If you would like to schedule a free presentation at your office or clinic, you may contact Lori. Also, the Colorado Children's Immunization Coalition Standards of Practice Task Force is developing a computerized audit of clinic practices to measure immunization levels of two year old children and reasons for inadequate levels. If you would like to have your practice reviewed free of cost, and in a

confidential manner, please contact Lori. Should you have any questions about the nature of the audit or the activities of the Standards of Practice Task Force, please contact Dr. Paul Melinkovich at (303)436-7433.

## Burn Alert

According to the Colorado Department of Health, restaurant workers exposed to deep fryers are at

risk of suffering severe burns requiring inpatient hospitalization. Hospitals in Colorado reported 31 restaurant worker burns between February 1989 and September 1993. Over half of these injuries (16 of 31) were related to exposure to deep fryers.

The Colorado Department of Health strongly urges physicians to advise patients who may be at risk, of the dangers of deep fryers.

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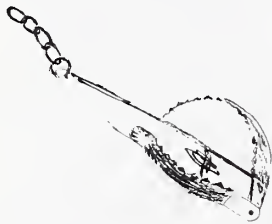




## RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor



I was delighted but not surprised to read the news story about my broker ("**Pawnshop owner unloads on crime**" - *Rky. Mtn. News*, 3/1/94; pg 4) and his sacrifice to help end street warfare. It was about Charles Kaufman, owner of "Al's Loan Office" at 21st and Larimer in Denver who gave the Police 111 guns to be destroyed, saying he would no longer buy or sell guns so they wouldn't get onto the street.

When I say it didn't surprise me, I've known Charles Kaufman for 33 years (he is my pawn broker) and know the strength and depth of his feelings about Denver, its joys and its problems. He sees a lot of both every working day.

Funny what a rush of memories the story about Chuck brought back. It was Al's Loan that served as a principal stop on my "trap line". As a working news person, I had a fairly regular beat, but generally would just run the traps to see what I got from day to day. People would know I was coming and, unconsciously, would save up information or stories for me. There was Al's Loan, the beat cops whom I would usually see at one time or another on any day, stopping at the "Circus" bar and lounge for coffee or a meal (I had known one of them years before when his wife worked for me in the restau-

rant business). There was the chop suey cafe, Denver Fire Department Engine 3, Engine 5 and Ladder 10, Darrell's barber shop, Leon's Cleaners, Mrs. Robnett, the Top Hat, White Mule and others.

Engine 5, Denver Fire Department, 19th between Larimer and Market, got in on a lot in town. Engine 3 out at 25th and Washington in 5 Points was an excellent stop, too. The ladder company at 32nd and Curtis was a good stop. The fire houses were real institutions in those days. Those were good days. Mrs. Robnett lived just north of the Engine 3. She was 103 years old when I saw her last. She had lived there a long time and had raised her family, two of whom became professionals. We used to talk a lot.

Also up in the Points was Davis Cleaners. Leon Davis was another beautiful human. I would go see Leon just because he made me feel good about humanity. Leon and I became fast friends and I'll never forget him. Age caught up and he moved back to St. Louis to be with his old friends.

A variety of people would often meet at the Top Hat, a coffee shop cum local card room south of the Rossonian Hotel on Welton. That is, we did until the feds pulled a raid one afternoon and picked up Amos "Hippy" Walker at the Top Hat. He was charged with dealing drugs and some other things. I don't know what happened to him after that. I remember some other experiences in the Top Hat that I thought at the time my life would probably end by gunshot right there, but that's another whole chapter of the book.

That little "mom and pop" (if you could call it that) chop suey cafe on 19th up toward Lawrence; they were

great, and very colorful. He with the Confucian moustache and goatee, always wearing a felt hat while he cooked; she doing the serving; the tiny dining area and kitchen separated by Casa Blanca hanging beads in the doorway. I used to ride with the district police cars and we'd eat a midnight "lunch" there often. There was Detective Abe Levine on the pawn-shop detail. He was also one great guy!

Darrell's Barber Shop was not too far away. That was the best news producer, because a majority of Denver area officialdom got their haircuts by Darrell. No appointments, no fancy stuff. The Chiefs of Police, the District Attorneys, got handled just like anyone else.

Close by was the "White Mule", one of your more basic downtown refreshment stands.

Now why did I start talking about the trap line? Oh yes. It was because the newspaper picked up on what Chuck Kaufman was doing about street crime. What Chuck did to and for the stereotypical pawn broker or "hock shop" operator was outstanding. I could certainly see how, when the public read the story, they might get a very different and very elevated impression of the pawn broker.

Why does this story work for a pawn broker, while the same kind of good-hearted giveaway that physicians make every day seldom hits the news? They give services and medicines worth much more on the street than 111 used guns. They save lives! Never have they dealt in anything to take lives! They don't have to quit anything!

I guess the docs need a trap line.

Thanks Chuck. I wish the world had many more of you.



STACKS

# COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

1994

Volume 91, Number 5

## Call for Nominations



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Issue:

**Health Care using OPM (Other People's Money)**

*by Wm. Carl Bailey, MD, CMS President* ..... Page 171

**Medicaid Wants to Help Balance Your Checkbook** ..... Page 178

**Current Reality ca. 1969** ..... Page 198



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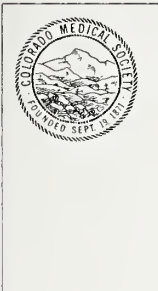
May, 1994

Volume 91, Number 5



## Cover Story

Physicians as a whole contribute immeasurably to their communities. The Robins award singles out a physician who shines above the rest. See Page 199



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# Computer Talk

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## How *Not* to Buy A Computer; The 7 Deadly Sins

One of the most important assets you will acquire for your practice is a business computer system. Whether it's your first system or a replacement system, the selection process is a tricky one, as too many disgruntled buyers will attest. Computer disaster stories abound.

If you can avoid the following seven most common buying mistakes, however, you stand a very good chance of implementing your new system successfully:

### 1. **Single Minded Focus on Price.**

Certainly the cost of a new system is important. But because most systems appear to offer the same features, many buyers succumb to the temptation of simply picking the least expensive one. This is especially true for hardware. In an interesting survey undertaken recently by a Canadian market research firm, those purchasing a system for the first time selected price as their number one criteria out of 10 possible. Support was 8th. Of those buying a system for the second time, *price was relegated to the 9th position, and support became number 1.* The experienced buyers learned their lesson - the hard way.

### 2. **Failure to Check Out the Vendor.**

Financial instability is a lot like cardiovascular disease: even the most healthy looking can be silent time bombs. Over the years, many big players have vanished, including such "solid" names as McDonnell-Douglas (whose medical computer division lost millions until it was finally shut down). Have your accountant or business manager

acquire a Dun & Bradstreet report on your prospective vendors before you make your first appointment with them. Large debt ratios, disputes with suppliers, and lawsuits (past and pending) are big, bright red flags.

### 3. **Failure to Obtain a Proper Fit.**

Don't acquire a computer system solely on the basis of a colleague's recommendation. While this is certainly a good starting point, make the same detailed analysis of *all* vendors. Practices which appear on the surface to be very similar in nature often have very different requirements, even within the same specialty.

Also, do not purchase a closed, proprietary system. Stick to *de facto* industry standards such as *Unix, DOS, Windows, Novell, Macintosh*, etc. Not only will this help you preserve the dollar value of your system, it will also help you be prepared for unpredictable changes in such things as data interchange and telecommunications standards (e.g. electronic billing).

### 4. **Excluding Office Staff From The Decision.**

This situation is best described by the infamous "Three R's": **Resistance** ("What do we need a computer for?"), **Resentment** ("Well, nobody asked *me*."), & **Revenge** ("I *told* you it wouldn't work"). By inviting staff members to express their opinions and concerns, and to attend sales presentations from prospective vendors, you can reduce the risk of encountering these dangerous trip wires considerably.

### 5. **Improper Conversion.**

Since the conversion of data from your old system to the new one is the most important step in implementing your new system, *leave it up to the vendor wherever possible*, even if you have to pay extra for it. And don't automatically insist on an electronic conversion. Leave that decision to your vendor, who ostensibly knows better. Just get a written guarantee that the conversion will be 100% completed by a specific date and leave it at that.

### 6. **Insufficient Training and/or Support.**

Get as much training for your staff as is available. If this requires you to pay more, or to pay for employee overtime, do it. The return on this investment is high, as is the price of avoiding it. So spend the time and money *now* to get your staff comfortable with the new system as quickly as possible.

The same is true for support (remember the Canadian survey). The absence of timely and accurate support - for both software and hardware - can cost you dearly. Get ongoing support contracts for both, and keep them current. And be sure to ask if software updates are included.

### 7. **Inadequate References.**

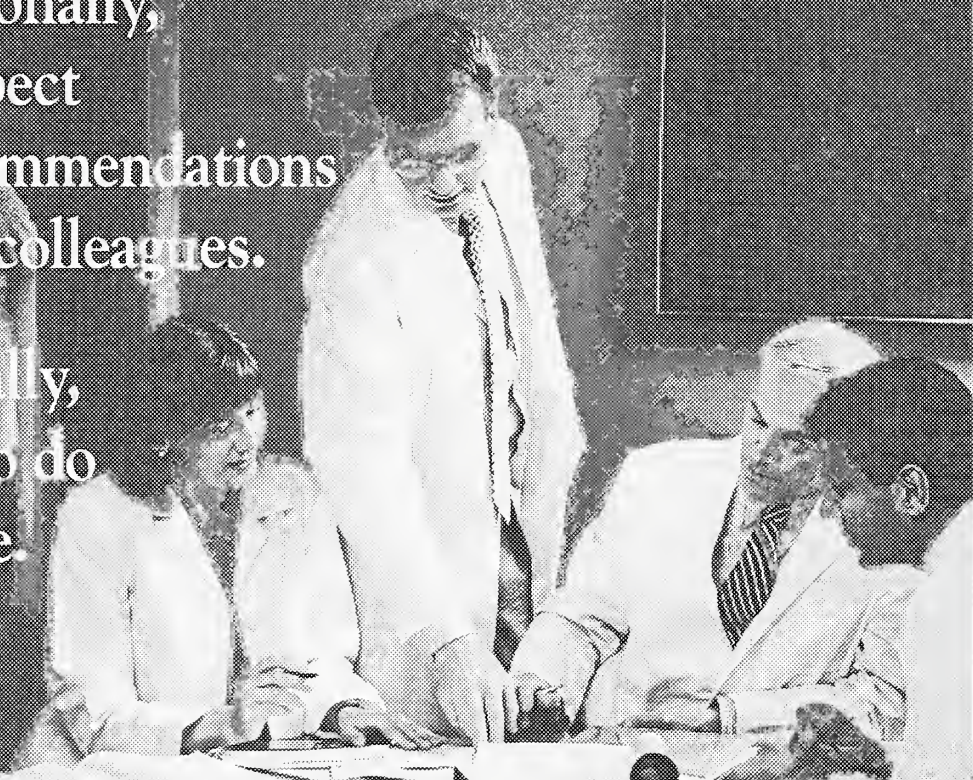
Check references. If possible, visit the reference practices. Prepare a list of questions to ask each one. In addition to the functionality of software and hardware features, ask about conversion, training (including ongoing training for new employees) and updates.

As with most things, an ounce of prevention is worth a pound of cure. You may quote me.



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Wm. Carl Bailey, MD  
President, 1993-1994

## Individual responsibility and spending other people's money

Consider for a moment the salesman who takes a client to lunch on an expense account. It is not surprising that the client-guest (encouraged by the salesman) elects to order the elegant full course luncheon menu instead of the sandwich he usually orders. The consumer's choice in this instance has been significantly affected by the fact that neither he nor the salesman were paying for the meal, but rather a third party.

Our health care payment system functions a lot like this. Patients and physicians are in fact spending other people's money on health care and the market forces that normally control most commercial transactions are controverted or at least badly skewed. There is no *en face* fiscal relationship between the person providing the service, and the patient who receives it. When a commodity is paid for in this way the ability to assess value and to negotiate costs, which would normally be present in the purchase of any other commodity, is destroyed. Haavi Morim, in her book **Balancing Act** (Kluwer Academic Publishers, 1991) says it succinctly: "Where one party spends and someone else pays, the inevitable result is a serious distortion of both value and cost. Without patients' involvement on both sides of the equation, this distortion probably can never be corrected."

The loss of *autonomy*—perceived both as *freedom* and *responsibility*—is the price to be paid by the patient when someone else pays for his health insurance. One can not be autonomous without responsibility and freedom, contrary to the

notion currently popular among some health professionals. In such a system the patient may find he has not only lost the freedom of choice of physician, practice setting, and some therapeutic options, but he has also lost his right to be treated as a real moral agent, to make real moral decisions about himself.

It is frustrating, too, for the physician. In this scheme, the third party payer (whether government, employer, or insurance company) "owns" the patient. This places the physician in a different role. That bonding created when the patient freely selects the physician is lessened, if not destroyed, before it starts. How can you expect even the well intended, compassionate physician to become totally immersed in the clinical aspects of a truly difficult or complicated patient matter when relationships may be severed at any time by some administrative fiat? How can that physician guide patients through mazes of therapeutic choices and ethical decision-making, as well as deciding or advising on complex economic issues, when the patients are strangers and the economics controlled by a third party? To truly care for the patient, it is said, one must in fact **care about** the patient. Relationships are not nurtured in a series of irregular encounters controlled by intrusive third parties.

Currently we are hearing that not only the Clinton Plan, but others as well, are too expensive, and probably will not be enacted. It is certain that we must reduce costs of health care in this country. I submit that to do so, two things must happen.

### ***Relationships are not nurtured in a series of irregular encounters controlled by intrusive third parties.***

First, we physicians **must** create new efficiencies in the delivery of health care. Large groups, owned and **managed by physicians at risk**, collaborating closely on the solution of clinical and management issues **can** do it. The success of this is already being demonstrated in some parts of the country. CMS is currently studying the practicality of **establishing physician networks in Colorado**. We'll be reporting more on that in the near future.

Second, the consumer (patient) **must become a responsible user of health care**. That same person must be given the ability to choose quality care as he or she perceives it. I believe that the **Individual Mandate** for health insurance, as suggested by many of us (including **Susan Adelman MD** in *AM News* some weeks ago) offers great promise. Such a system would foster patient autonomy and encourage both fiscal and personal health responsibility by the individual, at the same time it reduced costs. Every citizen would be required by law to select and to own a health care insurance policy. This could be monitored by the IRS,

JOURNAL OF THE COLORADO MEDICAL SOCIETY



## PRESIDENT'S LETTER

(continued)

with a system of incentives and penalties to assure compliance. A health security card would be required to obtain medical care, to be hired, or to apply for unemployment or welfare benefits. This policy would be completely portable. It would eliminate pre-existing condition exclusions, and be based on community rating. Purchasers would be able to join health care cooperatives to enhance their bargaining position. Employers could, if they chose, offer the premium as a benefit, but would not select or own the policy. This would help make the risk pool more equal to the benefit pool. All members of society, unless they were medically indigent, would share in the risk for providing that care by owning a policy covering at least the basic benefit package.

This measure would encourage consumers to seek cost-effective health care of their own choice. It would eliminate many of the most unfair aspects of our present non-system. And with the Individual Mandate the cost shifting, which produces excessively high premiums now being paid by the responsible

citizens, could be ended. In a state such as Colorado, most of whose people are self-employed or in small business, it may be the only eco-

nomically viable possibility for universal health care.

I invite your comment as we prepare for the debate ahead.

## Endocrinologist

Seeking BC/BE Endocrinologist for community of 120,000 in northern Colorado. Successful candidate will be able to choose type of practice setting.

Greeley is located 50 miles north of Denver, has a strong economic base, a 326 bed regional tertiary care hospital and a large university. Greeley is an ideal family community with an excellent school system, growing community and easy access to Denver and the mountains. Candidates should send CV to:

**Sherry Kozero-Roth,  
Physician Support Services,  
North Colorado Medical Center,  
1801 16th Street, Greeley, CO 80631,  
FAX (303)350-6644.**

## CMS Leadership Goes to Washington



CMS President Wm. Carl Bailey, MD and American Medical Association Alliance President Mary Hanson of Colorado Springs, are among those leaders in health care who stood united in support of health system reform principles during the American Medical Association's March 8 summit in Washington, DC.



Sandra L. Maloney  
Executive Director  
Colorado Medical Society

## Social Services EFT directive for Medicaid physicians

On Thursday, April 14, 1994, Colorado Medical Society received several telephone calls from physician members stating that they had received a form from the Department of Social Services pertaining to direct payment for Medicaid services.

These calls gave CMS its first indication that the Electronic Funds Transfer system to be used by the Department of Social Services was going to be a two-way street, allowing the state debit and credit access to the physician's bank account.

Colorado Medical Society has never been informed of any such mandatory direct payment and withdrawal system. CMS staff has monitored the development of the "Automated Medical Payments (AMP) system and electronic claims submission, and has eagerly published any related information to our members. (*Colorado Medicine* Vol. 91, No. 2; Feb., '94) carried the Department of Social Services story on AMP and Electronic Fund Transfer, but there was no mention of debit-credit adjustments to the participant's bank account. Colorado Medical Society would have been the first to advise its members of any electronic payment system which would allow the State of Colorado to enter a private bank account and remove funds. There was never any mention of such a plan.

The immediate reaction of CMS was to contact all of the persons at the Department of Social Services directly involved and who would be responsible for any such "authorization agreement". CMS was told that the form was standard and was

required in any direct-payment program conducted by the State of Colorado, and the State Comptroller required the wording of the agreement allowing the state to enter the bank account and "if necessary, debit entries and adjustments for any credit entries in error..."

During these conversations, CMS pointed out that the wording of the form did not make clear what the state wanted to do or COULD do in these accounts, and that most physicians would refuse to sign the agreement until the wording was changed. CMS was further informed by David West, Director of the Department of Social Services, that he was attempting to have the wording changed.

Meantime, calls have continued to come in and CMS can only advise physicians to hold off signing the agreement or providing any further information to the state department or to their bank or, in the case of their having already signed the agreement, to retract that agreement based on the very questionable wording.

On Thursday afternoon, April 14, at approximately 3:30 P.M., CMS sent a news release to the majority of news media in Colorado, stating its discomfiture with the "Authorization Agreement" and further advised the public that this was viewed as a very effective way of driving the remaining physicians away from the Medicaid program, further limiting medical service to this area of need.

CMS staff is continuing to stay in close contact with the Department of Social Services and will report any further development in both the form

***... allowing the state to enter the bank account and "if necessary, debit entries and adjustments for any credit entries in error..."***

of news releases to public news media and a full report and disposition of the matter in this issue of *Colorado Medicine* (see "MEDICAID: THE MOST RECENT FLURRY OF ATTENTION" in this issue).

As a result of CMS's intervention and discussions with the Department of Social Services, CMS received (April 15th) a letter written by the Department which, to the best of our knowledge, is to be mailed to all Medicaid participating physicians who received the earlier "Authorization Agreement." This letter explains the Department of Social Service's motivation in sending out the "Authorization Agreement" and works to mollify the large percentage of physicians who say they'd sooner drop out of the program as to give someone their bank account number.

All I can say is, for the sake of all parties I hope this works.



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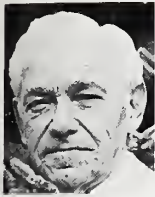
## Physician Recognition Awards

*The Colorado Medical Society joins the American Medical Association in recognizing the following physicians for their dedication to excellence in the profession of medicine, as demonstrated in their commitment to continuing medical education.*

Franklin D. Aldrich  
William H. Alexander  
A. Lee Anneberg  
Joseph R. Becky  
Brice J. Bender  
Frank R. Carson  
Herbert N. Chado  
Barbara J. Gerhardt Chase  
Michael Cherington  
Thomas G. Chiavetta  
Lawrence E. Cormier  
John W. Doucette  
William E. Emeis  
G.T. Jim Foust  
Patrick D. Gerstenberger  
John S. Gray  
Robert R. Greenheck  
Lynn F. Greenlee  
James J. Gregory  
Michael D. Grossman  
Steven J. Gulevich  
Gerald M. Haase  
Belton D. Hallmark

Jerome R. Hanson  
Philip M. Henbest  
Rebecca A. Henry  
Glenn O. Hewitt  
Daniel A. Hoffman  
Steven A. Holt  
Andre J. Huffmire  
Vaughn A. Johnson  
Jeannie J. Kinzie  
Michael L. Lepore  
Joanne MacEachen  
Jack L. Mackey  
Anthony J. Makowski  
Alan J. Margolis  
William D. Merkel  
M Keith Miller  
Timothy W. Morgan  
Robert D. Mc Cartney  
Marisa Moritz  
John D. Newell  
Garold L. Paul  
Norman P. Payea  
Carol M. Phelps

Martin P. Pirnat  
Jay S. Rabinowitz  
Michael G. Rappa  
Charles W. Reiquam  
Christine M. Rodgers  
Harold H. Rohrer  
John E. Sadler  
Victor L. Schramm  
Aaron J. Shwayder  
John L. Smith  
Cathy S. Smith  
Myron C. Smith  
Marc J. Sorkin  
Alfred C. Speirs  
Le Roy H. Stahlgren  
Gordon K. Tagge  
Celsa T. Tiu  
Christopher N. Tulin  
Guy P. Van Der Werf  
Joanne M. Vitanza  
John L. Wiberg  
Paul D. Wiesner



Frederick A. Lewis, Jr., MD  
Chair, Council on Legislation  
Colorado Medical Society

One of the difficulties in writing this column is that the legislature moves swiftly, while it is a month before my written words appear in Colorado Medicine. I hope the readers will be indulgent if my remarks occasionally seem out dated.

HB 1186, which was the focus of my remarks last month, did not make it through the House Appropriations Committee and is dead for the session. This is the bill which attempted to define a primary health care provider and a primary mental health care provider in Colorado statute. The bill will probably return in 1995.

One of the criticisms which has been leveled, over the years, is that the CMS is "against" too many bills and does not adopt a sufficiently positive legislative stance. On the surface, this appears to be a legitimate criticism. The truth is that we are opposed to more bills that we support and we sometimes support, in lukewarm fashion, bills with which we really do not agree but we are reluctant to be perceived as obstructionists.

However, there may be a very good philosophical reason for this posture - an explanation which does not require one to assume the CMS physicians are Neolithic arch conservatives who are only interested in maintaining the status quo, circa 1960. (Pre Medicare)

The fact is that modern medicine is a rapidly changing discipline, both scientifically and socio-politically. It is difficult to conceive of many constructive legislative acts regulating the practice of medicine which

could be passed in 1994 and not run a considerable risk of being obsolete in 1996.

For instance, in 1991 the Colorado legislature passed SB 218, which deals with determination of permanent impairment under Workers' Compensation. This bill, enacted into Colorado statute, stated that impairment should be rated using the "AMA Guides to Permanent Impairment," 3rd edition, revised. In 1994, the 4th edition was published and the 3rd edition is no longer in print.

One would think that it would be a simple matter to make this change in Colorado statute. Unfortunately, the CMS is currently involved in a controversy with the powers in the Colorado legislature. We would like to amend the statute to read "most recent edition"; they want to stick with "3rd edition." At the time this is being written, it looks as if we will lose and physicians in Colorado will be forced to continue using a book which is no longer available.

All of this presents a powerful argument for passing as few laws as possible which freeze the practice of medicine to the spring of 1994. We should persuade the legislature to attempt to only legislate those things which are unlikely to change.

The CMS has supported anti smoking bills, bills which mandate the use seatbelts, supported bills which mandate the use of helmets by motor cycle riders. These advances in public health knowledge are not likely to change.

I submit to you that the definition of a primary health care provider does not fall into the realm of

*"It is difficult to conceive of many constructive legislative acts regulating the practice of medicine..."*

*continued on following page...*



## THE LOBBY (CONTINUED)

---

*It is difficult to conceive of many constructive legislative acts regulating the practice of medicine which could be passed in 1994 and not run a considerable risk of being obsolete in 1996.*

immutable scientific or socio-political facts which are unlikely to change. There is simply no reason to codify this into Colorado statute unless someone plans on utilizing this definition in 1995 or 1996 to further define the role of a primary health care provider versus a "non primary" health care provider. This would not be in the best interest of the citizens nor physicians of Colorado.

In the same vein, it is unclear why Colorado needs legislation, at the present time, which sets up voluntary cooperatives and networks, defines what data should be collected from physicians, or mandates that physicians post the BME telephone number in their waiting room. All of these are things or concepts which may change over the next two years.

I submit that the CMS should oppose this kind of legislation, not because it is good or bad in 1994 but simply because it is something which should not be mandated by legislative statute.

Cutting to the chase, 1995 is going to be a difficult legislative year for medicine. Among other things, the practice acts of physicians, nurses, pharmacists, podiatrists and chiropractors will be up for review. It is imperative that organized medicine attempt to speak with one voice.

We made a sincere effort to promote this concept in 1994 and were unsuccessful. The CMS will try again next year. I would urge all of

the physicians in the State of Colorado who belong to specialty organizations which hire lobbyists to pressure your organization's Board or Legislative Committee to work collaboratively with the Colorado Medical Society in terms of legislative initiatives which impact medicine. This does not imply that the CMS is expecting blanket concurrence. It does mean that we would expect your society to send a representative to legislative meetings who has the authority to negotiate and enter into binding agreements, expect that your society would be honest, open and forthcoming about its stance on various bills, and make certain that your lobbyist does not have conflicts of interest about which you are unaware. Unless you do these things, medicine will remain fragmented in the 1995 legislature and we will deserve what we get.



# Access to Food Constitutes a Human Right

World hunger is an  
ever-present scourge that claims  
35,000 lives each day.

Access to food constitutes a human right. In 1976, the United States Congress passed a Right to Food Resolution which declared the sense of the congress to be "that all people have a right to a nutritionally adequate diet".

**Physicians Against World Hunger (PAWH)**, a non-profit, tax-exempt organization was founded so that physicians could collectively defend this human right by raising funds to support well-recognized, reputable organizations that are directly engaged in working with the poor primarily for the purpose of ending death by starvation.

Please join us — together physicians must help bring an end to world hunger.



## Physicians Against World Hunger

#2 Stowe Road, Peekskill, NY 10566

☐ YES I wish to join PAWH in the struggle to end world hunger — enclosed is my contribution.

☐ \$50

☐ \$100

☐ \$250

☐ \$500

☐ Other \_\_\_\_\_

NAME PLEASE PRINT

ADDRESS

CITY

STATE

ZIP

SIGNATURE

Please forward your tax deductible contribution to Physicians Against World Hunger #2 Stowe Road, Peekskill, NY 10566





## MEDICAID (THE MOST RECENT FLURRY OF ATTENTION)

Bill Pierson  
Managing Editor

*During March, state newspapers ran headline stories heralding "\$30 million Medicaid wind-fall" and "\$54 million Medicaid surplus" caused by a miraculous "Medicaid recovery".*

*In April, Medicaid told physicians they were going to have to submit to electronic fund transfer if they wanted to be paid, and if they agreed, **Medicaid would have both debit and credit access to the doctor's bank account.***

*The medical practice field is not a level playing field.*

To the casual reader, the story seems to indicate that there are surplus Medicaid monies which are not going to be spent in the delivery of care to those nearly 285,000 enrollees; therefore, why can't some of those funds be used to pay caregivers who are now so poorly reimbursed for their services? In fact, in Colorado there is a large percentage of primary care physicians who simply do not bill for Medicaid patient care: **the billing costs more than the amount reimbursed.**

However (and here's where the casual reader goes astray), we're actually talking about apples and oranges when we talk about what ought to be paid for services versus what is budgeted but not spent.

The dollars that were returned by Medicaid were "budgeted dollars" that were not spent because of, for instance, lower than expected rate of growth in the number of people entering the Medicaid Program. You budget for ten and only six show up, 40% of the budgeted should be unspent. The legislature allocated dollars to cover the cost of Medicaid services based on an "expected" growth rate. When that growth rate is 6% less than anticipated, the program will not spend as much money. Hence, the "returned" or "surplus" Medicaid dollars.

**That's the "apples" portion of the discussion.**

Why can't this "surplus" money be allocated to reimbursement of caregivers?

Here, we have the "oranges" entering the picture.

Before any monies can be allocated to a cost or expense center,

the General Assembly has to direct that that money be set aside in the "long bill" or the State Budget. If current Medicaid regulation dictates that physicians will receive \$.57 on the dollar for primary care, that is the amount they will receive until that legislation is changed. No amount of budget surplus is going to get the doctor any larger payment.

In this case, the news stories trumpeted the relief of state budgeting officials when they said they could use the 1994-95 Medicaid surplus for additional prison facilities and education needs, they were merely saying that they already have budgetary shortfalls in those two areas which are critical, and this surplus can be redirected to be spent in areas where legislative spending authority already exists.

When queried by CMS offices about the surplus, State Acute and Ambulatory Care Services Director Allen D. Chapman said "A *Decision Item* that was submitted by Medicaid to the Legislature calls for rate increases to providers of primary care. This *Decision Item* is the Department's mechanism for 1) increasing selected rates and 2) increasing rates on an annual basis to keep pace with inflation. This *Decision Item* has been accepted by the JBC (Joint Budget Committee) in figure setting, which is a major accomplishment. However, we cannot take any action until July 1, 1994 provided that funds are provided in the Long Bill enacted by the General Assembly". Chapman adds that his department has already begun planning the use of these new dollars.

Mr. Chapman went on to say "Current plans call for an increase of \$4,179,950 for physician services, \$291,781 for dental services, and \$300,206 for medical transportation. [In the] draft of the projected increases to the RBRVU codes, the major emphasis is placed on reimbursement rates for established office visit codes (at least 80% of 1994 Medicare rates). Our goal is to have all rates for primary care services be at least 75% of current Medicare rates. As you can see we still have a ways to go, but by properly spending the annual increases called for in the *Decision Item*, Medicaid payments for primary care services will not fall behind payments for comparable services by Medicare."

Mr. Chapman continued, "I assure you that the State of Colorado is concerned about access to quality medical care for all Medicaid clients and that the above proposed rate increases demonstrate the Department's willingness to work with you and other providers of the Medicaid Program. I will keep you informed as to our progress in securing the approval of this proposal".

CMS Executive Director Sandi Maloney added that "We have closely monitored the Medicaid reimbursement issue, but we have not aggressively reported on the matter. I am directing you and the *Colorado Medicine* staff to be more alert in reporting such measures, particularly when it concerns a major policy shift such as Chapman's 'Decision Item'. Newspapers might have casual readers, but *Colorado Medicine* does not!"

### Then came EFT (Electronic Funds Transfer)!

Colorado State Department of Social Services sent out an "Authorization Agreement" form, saying if you, the Medicaid participating doctor, wanted to get paid for future services rendered, you would have to agree to allow the Department to electronically deposit payment into your bank account. There was, however, a fiat, which said you couldn't participate if you didn't agree to this, but in so doing, you also agreed to allow the State of

Colorado to have two-way access to your bank account. The form said this authorized the *"STATE, to initiate credit entries, and if necessary, debit entries and adjustments for any credit entries in error to our bank account indicated below and the Bank name below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account"*.

Did that cause a great flurry of confusion and protest? Yes!

And by the time we got it all

straightened out, the Department of Social Services sent out a letter the week after to all those who received the form. The letter (reprinted herein) was the Department's effort to explain what the Department *really* meant by the "Authorization Agreement" which caused all the fuss originally. For a full account of CMS's response to all this, see "Executive Director's Update" this issue.

## STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES  
1625 Sherman Street  
Denver, Colorado 80203-1714



Roy Romer  
Governor

Karen Bays  
Executive Director

April 15, 1994

Dear Medicaid Provider:

We have been made aware of concerns voiced about the letter that was recently sent to Medicaid Billing Providers that explained Electronic Funds Transfer (EFT) and the EFT enrollment documents. Hopefully, this letter will clarify the wording of the EFT enrollment form.

The EFT enrollment form, titled, State of Colorado Authorization Agreement for Automatic Deposits (ACH Credits) authorizes the Medicaid Program to deposit Medicaid payments directly into the provider's bank account. The statement "...To initiate credit entries, and if necessary debit entries and adjustments for any credit entries in error..." means that Medicaid is authorized only to correct any transmission or transaction error related to the direct deposit. For example, if a weekly payment is inadvertently transmitted twice or posted by the bank twice, Medicaid would debit the account to recover the duplicate transaction. **MEDICAID WILL NOT DEBIT YOUR BANK ACCOUNT TO RECOVER OR ADJUST INCORRECT CLAIM PAYMENTS.** Claim adjustments will be processed through the claim processing system in the same way that they have always been processed.

We certainly regret any inconvenience to providers or misunderstanding resulting from the wording on the enrollment form. We believe that EFT will prove to be a significant benefit to providers by reducing payment turnaround time, eliminating paperhandling, postal service delays, and misdirected mail.

Thank you for your continued participation in the Colorado Medicaid Program. Questions about Medicaid billing and Medicaid payments should be directed to Medicaid Communications at the following telephone numbers:

Practitioner Operations (303) 831-0504  
1-800-443-5747

Institutional Operations (303) 831-0214  
1-800-443-6731

Please note, if you did not receive the EFT letter, it is because your claims are submitted by and paid to a clinic or professional corporation. This letter is simply a clarification that is being sent to all providers whether or not they received the EFT letter.

Sincerely,

*Marianne Seddon*  
Marianne Seddon, Director  
Division of Administration  
Health and Medical Services



**STATE OF COLORADO  
AUTHORIZATION AGREEMENT  
FOR AUTOMATIC DEPOSITS (ACH CREDITS)**

I (we) hereby authorize the Department of Social Services, State of Colorado, hereinafter called STATE, to initiate credit entries, and if necessary, debit entries and adjustments for any credit entries in error to our bank account indicated below and the Bank named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

APPLICATION (Payment Type)	MEDICAID PAYMENT (34)
----------------------------	-----------------------

ENTITY NAME \_\_\_\_\_

FEDERAL E.I.N. NUMBER \_\_\_\_\_ MEDICAID PROVIDER # \_\_\_\_\_

ADDRESS: \_\_\_\_\_

## BUILDING

STREET \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

DEPOSITORY NAME \_\_\_\_\_

BRANCH \_\_\_\_\_

ADDRESS: \_\_\_\_\_

## BUILDING

STREET \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

DEPOSITORY TRANSIT NUMBER

DEPOSITORY ACCOUNT NUMBER

CHECKING		SAVINGS	
----------	--	---------	--

**(Please attach one (1) deposit slip)**

**This agreement is to remain in full force and effect until the STATE has received written notification from the ENTITY of its determination in such time and manner to afford STATE and DEPOSITORY a reasonable opportunity to act on it. It is the responsibility of the ENTITY to fill out a new agreement if the ENTITY changes banks or accounts.**

Date \_\_\_\_\_ Phone No. \_\_\_\_\_

**Authorized Signature** \_\_\_\_\_

[illegible]

**Authorized Signature** \_\_\_\_\_

[illegible]

## Colorado Medicaid physicians told to open their business bank accounts to the STATE for "adjustments".

COLORADO PHYSICIANS WHO TREAT MEDICAID PATIENTS THIS WEEK RECEIVED A STATE AUTHORIZATION AGREEMENT WHICH WOULD REQUIRE THAT ALL MEDICAID SERVICE PAYMENTS BE MADE ELECTRONICALLY. THIS MEANS THAT WHEN THE STATE AUTHORIZES A PAYMENT FOR MEDICAL SERVICES IT THEN ELECTRONICALLY TRANSFERS THE AMOUNT INTO THE PHYSICIAN'S BANK ACCOUNT.

THERE WAS, HOWEVER, ONE CONDITION OF WHICH PHYSICIANS WERE NOT MADE AWARE BEFORE RECEIVING THE FORM: THE FORM STATES THAT BY THE PHYSICIAN SIGNING THIS AGREEMENT, THE STATE ALSO HAS THE RIGHT TO **ENTER THAT PHYSICIAN'S BANK ACCOUNT AND MAKE EITHER DEBIT OR CREDIT ENTRIES OR ADJUSTMENTS**. THE AGREEMENT READS AS FOLLOWS:

**I (we) hereby authorize the Department of Social Services, State of Colorado, hereinafter called STATE, to initiate credit entries, and if necessary, debit entries and adjustments for any credit entries in error to our bank account indicated below and the Bank named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.**

AS ONE PHYSICIAN PUT IT, "THIS IS THE QUICKEST WAY TO GET RID OF THE REMAINING DOCTORS IN THE MEDICAID PROGRAM."

COLORADO MEDICAL SOCIETY TALKED WITH DAVID WEST, COLORADO SOCIAL SERVICES DIRECTOR, WHO SAYS THE FORM WAS MEANT TO SAY THE STATE HAS THE RIGHT TO MAKE DEBIT AND CREDIT ENTRIES IN THE EVENT OF A **STATE** ERROR, SUCH AS A DUPLICATE PAYMENT. HOWEVER, THE FORM CLEARLY DOES NOT SAY THAT.

WEST ADDED THAT AT THIS POINT (SOME 48 HOURS AFTER THE NEW AGREEMENT FORM HIT THE STREETS) HE DOESN'T KNOW WHAT IT WILL TAKE TO CHANGE THE WORDING, OR IF IT CAN BE CHANGED. WEST ADDS THAT THIS WORDING IS AT THE DIRECTION OF THE STATE COMPTROLLER AND IS MORE A MATTER OF STATE REGULATION ON A PAYMENT AUTHORIZATION FORM TO SAFEGUARD THE STATE IN THE CASE OF DUPLICATE PAYMENT. HOWEVER, THE FORM BLITHELY STATES "IF NECESSARY, DEBIT ENTRIES AND ADJUSTMENTS FOR ANY CREDIT ENTRIES IN ERROR TO OUR BANK ACCOUNT". THAT, SAYS THE PHYSICIAN, IS JUST A LITTLE TOO CASUAL A TREATMENT OF A DOCTOR'S FINANCIAL SECURITY AND PRIVACY. NEEDLESS TO SAY, MOST PHYSICIANS HAVE NOT SIGNED THE AGREEMENT.





### Oral Versus Written Approval — A Cautionary Note

from  
*Grant E Steffen, MD,  
Medical Director,  
Medicare Part B,  
Colorado Medicare  
Carrier*

A recurring and vexing problem for both the provider and the carrier is this: a provider calls in to get "approval" or "precertification" (the Medicare carrier does not do precertification) for a particular procedure or drug regimen and gets a response which the provider interprets as approval. However, on review the carrier determines that the service given was not a Medicare benefit or did not meet the requirement of medical necessity. The provider appeals and claims that the carrier gave approval. I am asked to adjudicate the appeal and have to decide whether our contact person didn't understand the request, gave a partial answer, gave the wrong answer, was misunderstood, or gave a correct response that was ignored.

Absent a recording of the phone conversation, I have no way of knowing where or why communication failed, so I make the best judgment I can. My advice is this. If the request is for a significantly expensive procedure or course of drug therapy, don't depend on a phone response alone. Write a letter to Medicare Policy and Support or to me and ask for a written response. Then you have a record of our response, the response in writing probably was more carefully crafted than an oral response might have been, and you have a document that will support your appeal if the carrier denies payment.

Another recommendation is this. Don't go through a "drug hotline" or other third party to get approval. That agency will call us and call you back with our response, thus doubling the chances of miscommunication. Also, do not depend upon the accuracy of newsletters from national societies that interpret Medicare policy. They are often correct, but sometimes not.

To contact the carrier for Medicare in Colorado:

Grant E. Steffen, MD,  
Medical Director,  
Medicare Part B  
BC/BS of Colorado  
700 Broadway  
Denver, Colorado 80273  
(303) 831-5827

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## Internist

An excellent group practice opportunity exists in northern Colorado for a BC/BE Internal Medicine physician. The successful candidate will take over an existing practice and have immediate access to an established patient base. The practice is located in Greeley, CO, an attractive community 50 miles from the mountains and Denver. Greeley has a strong economic base, a 326 bed regional tertiary care hospital and a large university. It is an ideal family community with excellent school system. Candidates should send CV to:

**Sherry Kozero-Roth,  
Physician Support Services,  
North Colorado Medical Center,  
1801 16th Street, Greeley, CO 80631,  
FAX (303)350-6644.**

## Prominent Denver Anesthesiology Professor Dies



Robert W. Virtue, MD

**Robert W. Virtue, MD**, of Denver, died in March at the age of 89. Dr. Virtue was director of anesthesia at the University of Colorado School of Medicine for 21

years, where he trained 100 young physicians and published 90 articles on anesthesia, hypothermia and cardiac surgery. Dr. Virtue was the husband of longtime CMS member Mildred Doster, MD.

In addition to his contributions to anesthesiology and medical education, Dr. Virtue was apparently very socially and politically perceptive. His foresight is well illustrated by a letter he wrote in 1968, warning that the passage of MEDICARE boded ill for physician autonomy and the patient-physician relationship. He even then suggested a physician-run plan for medical care to avoid having the government and the insurance companies run things without input from physicians. (See President's Letter by Dr. Wm. Carl Bailey (page 171) and Committee Update (page 192), both in this issue, for information on current CMS plans to start a physician-run network.)

Dr. Virtue warned in 1968 that, "Third parties give no thought to physician-patient relations. If third parties activate *their* plans," he said, "there's no question but that the quality of medical care will suffer." He told his medical colleagues that, "If such planning is done by other than physicians, patient relationships will suffer and so will the physicians' reputation....Physicians can either take the lead in this method of care, or have someone else do it."

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## CMS ALLIANCE



The purpose of the CMS Alliance is to assist the CMS in its programs to improve the quality of life through health education and services; to coordinate and advise the activities of its county Alliances; and to support the activities of the American Medical Association Alliance.

As the CMS Alliance begins its new year, I would like to extend a warm and sincere invitation to the spouses of all the CMS members to join the federation of Alliances (county, state, and national) this year. It's true that we are all busy with activities of daily living, but if ever there was a time we need each other, **it's now**. The problems facing us all are immeasurable, be it health system reform to the escalating violence in American Society. What group can better help you stay informed about legislation, offer leadership training, legislative affairs training, and is your support group in these troubled times?

The American Medical Association Alliance will install a new president, Barbara Tippins (Georgia) at its Annual Session in June. Ms. Tippins plans to continue the national focus on Family Violence, with special emphasis on violence and adolescents. The time for all of us to roll up our sleeves and find a solution to the problem of violence is long past. After witnessing the attempts of police and EMTs to save a stabbing victim, Bill Pierson stated in his column titled *Ruminations* (Oct. 1993), "I realized that it is no longer someone else's world I'm looking into. This is my world and I cannot view it as some stranger's incursion into my otherwise neat and

tidy place. I have to deal with it."

**We all have to deal with it and soon.**

Our children are our future, and many are being raised in "war zones" in the United States of America.

The county alliances/auxiliaries around Colorado are making a difference in their communities. Their health projects include funding the entire start-up costs for a Clinic at the Alternative High School in Larimer County, providing Health curriculum to Mesa County schools, furnishing rooms at Battered Women Shelters, and Homeless Shelters, funding scholarships for children to attend the Hall of Life, and many more.

I hope you will join us in the year to come as we attempt to deal with the problems facing us all. Together, we can be quite a formidable force.



*Patti Brown, President  
Colorado Medical Society Alliance*



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*A monthly report of current and ongoing activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.*

The **HEALTH AFFAIRS COUNCIL** met on March 17 and heard the following report from Dr. Jack L. Berry:

"After our monthly meetings, the three hour drive I ordinarily enjoy, through sometimes uninspiring terrain, offers one advantage, that of time for thought, reflection, and analysis. Last month's drive back was to St. Francis, Kansas, a community of 1,800 people just across the border where my partners and I staff a clinic once or twice a week because the entire county has no physician. More alarming was the fact that, as I drove for three hours and 190 miles after leaving the Aurora city limit, I did not pass

within 30 miles, and was usually at least 60 miles away from a single physician. I was struck by the thought that our committee needs direction and a project toward which we can direct the attention of a task force, and what more pressing need is there than aggressively addressing the medical needs of rural Colorado?

"There are currently one half the physicians in rural Colorado that there were 20 years ago (especially in the east, northwest, and mountains), and these decreased numbers are serving about the same population. The distances to basic medical care are often 60 miles and even farther to necessary, more sophisticated, life saving care. Risks with the least OB complication, MI or major trauma are markedly magnified for those individuals who live in this rural environment.

"Numbers of physicians is not the only problem. Current graduates of most family practice programs are academically well prepared, but are woefully ill prepared in the procedures and sophisticated lifesaving skills so necessary in the first minutes of most emergencies. They are quite literally terrified by what they will commonly be required to accomplish in a genuinely rural environment, and even if desirous and interested in a rural practice, forget about it and leave, or never even come look when faced with these realities.

"This state's rural population has essentially been medically ignored. As we enter into a time of medical reform which is consumer and primary care oriented with emphasis toward universal and equal access,

we must aggressively develop solutions to these problems or the state of medicine in rural Colorado will become ever more dismal. It is a responsibility of our Medical Society to develop policies and positions which will encourage the education and training of more and better qualified rural physicians, encourage a better physical, psychological and financial environment in which rural physicians can practice, and encourage these physicians to utilize all the varied health care professionals in a collaborative manner, so as to meet the overwhelming medical needs of our rural population. I believe we can best address these issues and answer these questions with a task force on rural medicine."

Following Dr. Berry's report, the Health Affairs Council established a task force on rural medicine. Many CMS members will be asked to assist in the deliberations of this task force in order to find solutions to these significant problems.

## Health Affairs Council Sets Priorities

At their March 17, 1994 meeting, the Health Affairs Council (HAC) determined their priorities for the coming year. The Council's charge states that they must "...study the provision of medical care and the changing conditions and anticipated proposals affecting the practice of medicine. Such issues shall include, but not be limited to, matters concerning the provision of quality medical care, socioeconomic issues,

public health issues, data collection, analysis and dissemination and third party payer issues." The Council is additionally charged with recommending and promoting policies of CMS in these areas, when appropriate.

The Council organized its priorities under the three main headings indicated by its charge, Socio-economics, Public Health and Third Party Payers. The priorities which emerged are listed below.

#### **Socio-Economics**

- Quality/Data Initiatives - A Data Task Force, chaired by Tricia Byrns, M.D., has been meeting for several months. This group has already completed one project: writing and subsequently submitting to the legislature recommendations on the collection and public reporting of physician specific data (published in the March, 1994 edition of *Colorado Medicine*.) The Task Force will make recommendations to HAC in May regarding the role of CMS with regard to data and quality activities.

- Allied Health Providers - A Task Force was convened to develop policy recommendations for CMS on practice paradigms involving physicians and non-physician providers (non-physician providers refers to physician assistants and advance practice nurses.) Such recommendations have been completed and will be reviewed by the Health Affairs Council at their April 21st meeting. Additionally, per discussions at last year's President's Planning Conference, recommendations will be made regarding representation of allied health providers in CMS.

- Health System Reform - A Task

Force is in place whose charge is, "to examine national and local health system reform proposals, formulate positions regarding them and suggest alternatives where it feels that the presented plan is contrary to the interests of CMS members and to their patients. As the Task Force studies health system reform issues, it will also make recommendations regarding modifications to current CMS policy on health system reform." This Task Force will report to HAC in June.

#### **Third Party Payers**

- Managed Care - The Council will be addressing all issues regarding managed care including resolutions referred from the Annual Meeting. The Council will additionally be reviewing and implementing current policy.

- Vertical Integration - Council members felt that the CMS membership ought to have some reliable resource to which to turn for information on vertical integration. The Council will be looking at different ways to educate the membership regarding vertical integration.

- Credentialing - CMS has received numerous requests to provide a credentialing service for its members. It was agreed at the last Council meeting that a Credentialing Task Force would be convened. This Task Force will initially study the feasibility of CMS beginning such a service and will report to HAC in June.

#### **Public Health**

- Rural Health - The Council determined that a Rural Health Task Force should be established and charged with developing policies and positions for CMS which would

lead to the development of solutions to the myriad problems associated with practicing medicine in rural Colorado. Dr. Jack Berry agreed to serve as chair. As a first information gathering activity, Dr. Berry and CMS staff will hold meetings in four areas of the state. Physicians who practice in rural Colorado have been invited to these meetings in order to discuss potential ways in which CMS might best address solutions to problems associated with rural medicine.

Meetings are scheduled in the following locations:

April 27, 1994 ---- Rocky Ford

May 12, 1994 ---- Craig

June 1, 1994 ----- Fort Morgan

June 21, 1994 ---- Cortez

Notice of these meetings was sent to CMS members who practice in rural areas of the state. If you did not receive notice and wish to attend a meeting, please contact Ellen Stein at the Medical Society at 1-800-654-5653.

- Youth - The Council agreed that their second public health priority would be a project which would focus on, and benefit youth in the state. A coalition composed of physician members, representatives of the CMS Alliance, the American Academy of Pediatrics and other interested organizations will be established. As their first order of business the coalition will decide upon a project. Potential topics suggested by the Council include: teen pregnancy, youth and AIDS, adolescent accessibility to care, TV/movie violence, early child abuse and assisting the Colorado Department of Health in efforts to establish a central database for childhood



immunizations that could be available to all physicians' offices. The first meeting of this group will be May 3, 1994 at 6:15 p.m. They will report to HAC in June.

#### **Ongoing Activities**

The Workers' Compensation Committee continues to meet on a bimonthly basis. Current activities include review of 1994 legislation related to Workers' Compensation and reviewing and commenting on proposed rules and regulations from the Division of Workers' Compensation. The Committee additionally addresses individual physician member issues as they arise.

The Committee on Professional Education and Accreditation (CPEA), Chaired by Dr. LeRoy Stahlgren, has ongoing responsibility for the accreditation of continuing medical education programs in the State of Colorado (approximately 37 organizations are currently accredited.) In addition, the Committee has recently been given responsibility for continuing medical education activities of the CMS. In March, a survey was sent out to approximately 35 rural hospitals around the state requesting information regarding CME related issues and concerns of rural physicians. The information gathered will be reviewed by the Rural Health Task Force and the Committee on Professional Education and Accreditation to determine if there are ways we can lend support to these physicians. CPEA will report to HAC in June.

## **Physician-Managed Health Care Network**

The necessity of exploring approaches to creating more affordable health insurance and increasing access to health care has led providers in many states to investigate forming local health plans owned entirely or in part by health care providers. These efforts present an opportunity for providers to develop for themselves a position of strength in what may soon be a reformed health care system.

The Colorado Medical Society House of Delegates at its 1993 annual meeting approved the creation of a task force to study the feasibility of sponsoring a physician managed organization. That task force has met a number of times and following is an article which includes background information explaining the reasons to develop a physician managed organization as well as a report of the task force's activities.

#### **Background**

There is a growing trend through managed care contracts to reduce physician access to patients. A key concept in understanding the desire to create a provider owned and managed health plan is that value within the health care system is obtained from "access" to the patient contract. In the past, physicians had this through their direct relationships with their patients. Today, insurance companies own the patient contract and, therefore, dictate what physicians their members see. By

creating a physician owned health plan, physicians would take a step toward reestablishing the direct link between patient and physician.

In managed care contracts patients are at risk of losing access to their choice of physicians. By creating a statewide physician organization open to all physicians who meet the credentialing requirements and ongoing utilization management and quality assurance criteria, access to patients' choice of physicians will be improved.

Physicians are losing control over their day to day practice of medicine due to increasing requirements from third-party payers. Most distressing among these are utilization management and quality issues which often do not incorporate appropriate physician involvement.

Physicians are also expressing concern about being arbitrarily excluded from provider networks. As individual provider networks continue to grow and merge, this issue will become increasingly critical to physicians. As mergers continue to occur, we will move closer and closer to a system where a small number of very large managed care organizations will dominate and control a significant percentage of the health care provided in Colorado.

Finally, physicians have a responsibility to contribute to efforts to improve access to health care for those who need it and may not be receiving it. The task force felt very strongly that in addition to this venture being a viable business entity, it must also have a social conscience. For example, it should make Medicare and Medicaid

participation mandatory. It should also seek creative ways to improve access for the medically underserved through a variety of strategies.

Following are the goals which should be reached in an effort to address the problems stated above:

Goals:

1. To provide improved access to health care for all the people of Colorado.
2. To improve the quality of health care in Colorado.
3. To lower the cost of health care in Colorado.
4. To encourage the independent practice of health care in Colorado.
5. To promote freedom of choice of providers for the people of Colorado.

To reach these goals, it is being proposed that CMS sponsor the development of a statewide provider owned and managed health plan to offer health care services to the citizens of Colorado. This organization would be sponsored by CMS, but would be completely separate entity from CMS.

The organization would provide "open access" to physicians and possibly other providers, meaning that any provider who met the participation criteria would be welcome to join. Consequently, it will allow a broad choice of providers. Effective utilization management will be essential in this environment.

An equitable mechanism for determining physician reimbursement will be developed.

Sophisticated information systems will be needed for successful

utilization management.

Task Force Activities

The IPA Task Force first met in November of 1993 to discuss the proposal described above. In addition to the Task Force, members from the community were also invited to the November meeting. Attendees represented pharmacies, hospitals, home health providers, lawyers, Department of Social Services, HMOs and the Division of Insurance. The purpose of this meeting was to determine the interest and/or resistance to the concept of a CMS sponsored independent provider association as well as any obstacles that might exist. The overall response from the group was positive and good questions and issues were identified.

The Task Force (task force members only) met in December to discuss the concept in further detail. Discussion topics included 1) antitrust issues, 2) whether to use a profit or non-profit structure and 3) the pros and cons of a variety of different legal structures for a statewide provider network.

Following is a summary of the key findings of research on this project over the last few months.

Statewide Coverage

At present no entity in Colorado has a statewide network of providers. Some believe that in Colorado, there may be an attempt to create a mandate for statewide coverage in order to assure adequate access in rural areas.

The Colorado Medical Society could create the opportunity to allow its members to participate from all areas of the state.

Open Access

Physicians and other providers have become acutely aware of the dangers of losing access to patients. They seem willing to trade off both fee schedules and the need for utilization management for access as, for example, in Medicare and Medicaid participation. Similarly, plans that offer significant freedom of choice of physician for patients can command a small but definite premium in the market.

Antitrust

CMS legal counsel has researched the antitrust implications of a venture of this type and concluded that based on discussions of the project so far, antitrust concerns seem manageable. This is primarily due to the fact that the project incorporates some of the key ways to avoid antitrust problems including economic integration (risk sharing), non-exclusivity, and pooling of capital. There is a mechanism by which we could get an advance ruling from the Department of Justice on whether or not they consider this proposed venture to be acceptable in terms of antitrust. However, we are unable to obtain a ruling until the organizational design is done.

Political Implications

We have discussed this project with several legislators and reception has been enthusiastic. At present, we do not believe that any new legislation is necessary. We are not requesting public funding.

Task Force Recommendations:

In accordance with RES-13-A adopted at the 1994 interim meeting a survey of a statistically significant number of CMS members is being developed and implemented.





# More alternatives in career development

Since the publication of *The Search for a non-clinical career* (April Med-Fax), we have discovered two other alternatives being pursued by physicians interested in some sort of career change. One is the American Academy for Physician Career Development (ACPD). The other is called "contract care".

## ACPD

ACPD was started by Joe Ann Jackson, formerly the Director of the AMA's Physicians Career Resource. Sensing a great need for these services, Ms. Jackson started her own business to take up the slack after the AMA cut funding for their program.

Ms. Jackson says the ACPD provides physicians with information on managed care, alternative careers, and employment opportunities nationwide. They will provide this information through a monthly newsletter, an annual seminar, and a job data bank. In addition, organizations recruiting physicians can list openings in their monthly publication, *MedCareer Counselor*.

Because of the rapid growth of managed care and impending health system reform, says Ms. Jackson, physicians are beginning to experience job stress as they undergo changes in their environments. This stress is related to increased government regulation, increased paperwork and more corporate work settings. She cites the Colorado Personalized Education for Physicians (CPEP), mentioned in last month's article, as one of two national programs helping physicians with career development. After a two-day assessment focusing on

clinical reasoning, medical knowledge, communication skills and patient-care documentation, the physician undergoes clinical interviews with practicing physicians in the participant's specialty and completes videotaped histories and physicals on actors trained to simulate specific cases. From the assessment results, an educational plan is developed that may take up to two years to complete. It may include CME courses, video courses, mini-residencies, preceptorships, correspondence courses or university training. (Call CPEP at (303) 773-0440.)

## Contract care

Contract care is a method being employed by physicians who want to retain some independence in today's managed care market. Rather than serving as staff physicians at hospitals or other facilities, these physicians work as independent contractors. In this way, they are able to practice where and when they choose, set their own schedules and fees, avoid being on call, and work full time or part time in the kind of facilities they desire.

Locum tenens contracts are another option, sometimes used by physicians who work nine months in their home towns, then three months in a vacation destination of their choice which is gearing up for a seasonal demand.

Keith L. Goding, Vice President of Spectrum Healthcare Services, the nation's largest provider of contract emergency department services, says, "another advantage of contract care is the relative ease of changing

hospital or healthcare facility locations, if doctors choose to switch assignments for any reason. Independent contract physicians don't have to be concerned about being perceived as a 'job hopper' by a future employer, because, despite changing hospitals or healthcare facilities, they continue to be under contract to one company."

Though started to meet increasing demands for staff in emergency departments, Spectrum and other companies have branched out, offering contracts in anesthesiology, radiology and primary care. Family practitioners, for instance, supplement their incomes doing contract work, or new physicians just out of residency use the additional income to help pay off medical school loans while deciding how and where to set up their own private practice.

***Here are some companies which help place physicians in various positions, including contract. No endorsement of any of these firms is implied.***

Vival McCarty .....	(800) 678-4562
Aftco Associates .....	(303) 771-0974
Colorado Community Health Network .....	(303) 861-5165
CompHealth .....	(800) 328-3084
Delta County Hospital ....	(303) 874-7681
Emergency Consultants, Inc .....	(800) 253-1795
Humana, Inc. ....	(800) 626-1590
Interim Physician Network .....	(303) 758-8677
Management Recruiters, Inc. ....	(505) 889-0606
Physicians Market Information Center .....	(800) 423-1229
Roth Young .....	(303) 755-0075
Skupsky & Associates .....	(303) 290-9480
Spectrum Healthcare Services .....	(800) 325-3982
Strelcheck & Associates ..	(800) 243-4354
Western Physicians Registry .....	(800) 437-7676



# Zidovudine Reduces Maternal Transmission of HIV

A report from the National Institute of Allergy and Infectious Disease (NIAID) of the National Institutes of Health indicates that Zidovudine (AZT or ZDV) therapy reduces by two-thirds the risk of transmission of virus from HIV-infected pregnant women to their babies.

An interim review of the study, AIDS Clinical Trials Group (ACTG) Study 076, revealed a transmission rate of 8.3% when both mothers and their babies received AZT, compared to a rate of 25.5% among those receiving a placebo. As a result of the study, and recommendations by an independent Data and Safety Monitoring Board, study investigators have stopped enrollment of women into ACTG 076 and are offering AZT to all currently enrolled pregnant women who remain in the study, as well as their infants for the first six weeks of life.

Study investigators plan to follow the infants for a number of years since long term effects of the AZT therapy are not known, however, there is currently no information to suggest toxicity in humans. The only observed effect in the study was a decrease in hemoglobin of less than one gram/dl, which did not require transfusion and resolved within several weeks of completion of ZDV

therapy. Six women (of 477 in the study) discontinued the therapy because of perceived toxicity, three from the ZDV group and three from the placebo group.

NIAID cautions physicians to counsel their patients on the substantial (8.3%) risk of transmission despite therapy. Consideration should be given both to the substantial potential benefit and the unknown long-term risks. General recommendations regarding treatment must await broader consensus on the balance between known benefit and unknown risk.

Results of this study are applicable only to women who initiate ZDV treatment between 14 and 34 weeks gestation, have received no other antiretroviral treatment during the current pregnancy, have base CD4+ lymphocyte counts greater than 200 cells/mm<sup>3</sup>, and have no clinical indications for maternal antepartum ZDV therapy.

NIAID does not recommend use of AZT for the prevention of maternal-infant transmission prior to the 14th week of gestation due to lack of information regarding use in the first trimester. However, if a pregnant woman is infected with HIV, the therapy evaluated in this study may be of substantial benefit to her infant.

from  
**Ellen J. Mangione, MD**  
*Director, Disease Control  
and Environmental  
Epidemiology*





### Addition To Morbidity and Mortality Reporting Regulations

At their January 19th meeting, the Colorado Board of Health approved an addition to the reportable causes of morbidity and mortality. The new rule requires the Department to tabulate fatalities that occur in association with pregnancy or for up to one year postpartum. These occurrences will be reviewed to compile potential risk factors. The rule will permit the Department to have access without patient consent to medical records of those cases for which an autopsy was not performed or was insufficient to fully determine risk factors for the death. The records will be protected from subpoena and search warrant.

The rule is intended to help the Department determine what proportion of pregnancy-associated fatalities are preventable. The information gained as a result of this rule may also help the Health Department design programs and educational efforts to reduce maternal mortality.

This change became effective March 30, 1994.

### Folic Acid Helps with NTDs

The March of Dimes has asked for help in alerting physicians to the efficacy of folic acid in reducing the risk of Spina Bifida or other Neural Tube Defects (NTDs). The Centers for Disease Control have recom-

mended 0.4 mg of folic acid daily for all women of childbearing age<sup>1</sup>. CDC notes that the effects of higher intakes are not known, and recommends that the dosage not exceed 1 mg per day, except under the care of a physician.

Women who have had a prior NTD-affected baby are at high risk of having another, so physicians should closely monitor and counsel patients of child bearing age, especially if they have had a previous experience with NTDs.

Each year in the United States, according to the March of Dimes, more than 2,500 babies are born with NTDs, and they are responsible for more than 500 infant deaths each year. Spina Bifida accounts for about 60% of NTDs, Anencephaly for about 35% and Encephalocele for less than 5%. Most babies (90-95%) born with NTDs are born to couples with no family history of the condition, however, previous NTD-affected children increase the risk for additional occurrences.

Research shows that use of a 4 mg folic acid supplement reduces the risk of occurrent NTDs by approximately 60% and recurrent NTDs by 72%.<sup>23</sup> Folic acid is available in green, leafy vegetables, enriched cereals and citrus fruits. For example, four bowls of raisin bran contain 4 mg; five cups of broccoli, 5 mg; seven cups of peas, 6 mg; and six cups of orange juice, 7 mg. vitamin supplements are also available with folic acid.

<sup>1</sup> *MMWR*. 1992;41 (RR-14):1233-1238

<sup>2</sup> *JAMA*. 1993;269:1257-1261

<sup>3</sup> *JAMA*. 1993;269:1292-1293

### National group targets drug interaction

The National Council on Patient Information and Education (NCPPIE) has joined the US Administration on Aging (AoA) in a television, radio and print public service campaign to educate patients about possible drug interaction. The campaign will urge consumers to ask physicians whether any new prescription medications will work safely with other medicines the patient is already taking.

More than 23 million Americans age 65 or older take an average of one to six prescription medications per day, some even more. Nearly one-fourth of all nursing home admissions result from older people being unable to take their medicines properly.

NCPPIE believes that the physician is the best person to educate patients about drug interactions, so the campaign instructs patients to ask their physicians, "Will this new medicine work safely with the other medicines I am taking?" If patients are currently taking several medications, the campaign urges them to put all the medications in a paper bag and bring it to the physician's office for review.

The television, radio and print campaign starts this spring, so physicians may expect questions on potential drug interaction.



## Help for Kids with Tumors

To you, a brain tumor is a diagnosis, an enemy, a mass; something to be dealt with. To a child who has one, it is much less defined and much more scary. It is difficult for them to accept your medical explanation and leave it at that. Yet, brain tumors are the second leading cause of cancer death in children up to age 15.

For these reasons and many more, the American Brain Tumor Association has published *Alex's Journey*, a fictional, first person account of a ten-year-old with recurrent headaches and stomach upsets caused by a brain tumor. This is an easily readable and highly informative book, appropriate for children with tumors, parents, friends or anybody who wants a more empathetic understanding of the experience.

The 56 page, illustrated, paperback book is available from the American Brain Tumor Association, 2720 River Road, Des Plaines, IL 60018.

## OSHA Issues Interim TB Enforcement Guidelines

On October 20, 1993, OSHA issued mandatory enforcement guidelines on occupational exposure to TB. According to OSHA, enforcement activity will be limited to five types of facilities whose workers have been identified by the Centers

for Disease Control and Prevention as having a higher incidence of TB than the general population. The five types of facilities are: hospitals, clinics, correctional institutions, homeless shelters, long-term care facilities and drug treatment centers.

The guidelines require that employers in the five above-named types of facilities institute the following measures to control TB exposure:

1. A protocol for the early identification of individuals with active TB.
2. Free initial TB baseline screening at the time of employment for all employees and subsequent annual tests. Those workers who may be frequently exposed to patients with tuberculosis or who are involved with potentially high-risk procedures should be tested semiannually. (Data on skin-test conversions should be periodically reviewed so that the risk of acquiring new infection may be estimated for each area of the facility. On the basis of this analysis, the frequency of retesting may be altered accordingly.)
3. Control and tracking of workers with positive skin tests.
4. Respiratory isolation rooms for infectious TB patients and hazardous procedures.
5. Training and information to ensure employee knowledge of such issues as the hazard of TB transmission, its signs and symptoms, medical surveillance and therapy, and site-specific protocols including

the purpose and proper use of controls.

6. Records of employee TB exposure and medical evaluations.

Additionally, OSHA is requiring employers to provide and ensure the use of NIOSH-approved high efficiency air particulate respirators as the minimum acceptable level of respiratory protection under the following circumstances:

- A. When employees enter isolation rooms housing individuals with confirmed or suspected TB.
- B. When employees perform high-risk procedures on persons with suspected or confirmed TB. Examples of high-risk procedures include aerosolized medication (e.g., pentamidine) treatment, bronchoscopy, sputum induction, endotracheal intubation and suctioning procedures, and autopsies.
- C. When emergency-medical response personnel or others transport, in a closed vehicle, an individual with suspected or confirmed TB.

Whenever respirators are required to be used, a complete respiratory protection program must be in place according to 29 CFR 1910.134(b).

The guidelines from which the above information was taken are interim guidelines. OSHA's final guidelines will be based on the CDC's TB Guidelines, which are expected to emerge sometime in 1994. (The most recent draft of the CDC's Guidelines for Preventing the





Transmission of TB in Health Care Facilities was published in the October 12, 1993 *Federal Register*.)

Notice on how to obtain a copy of OSHA'S final TB Guidelines will be placed in *Colorado Medicine* once the guidelines are published.

### Recent Interpretations of the Bloodborne Pathogen Standard

#### Reasonably Anticipated Contact

The Bloodborne Pathogen Standard requires employers to protect employees whenever there is "reasonably anticipated" contact with blood or other potentially infectious materials (OPIM). OSHA has interpreted "reasonably anticipated" to mean that if there is even a slight probability that employees will be exposed to blood or OPIM during their work, then the employer must fully comply with the Bloodborne Pathogen Standard.

An interpretation which OSHA recently issued to a chain of pregnancy care centers provides an illustration. Employees at the care centers occasionally handle open urine samples as a part of their administration of pregnancy tests. Because approximately 3 out of every 200 samples are visibly contaminated with blood the pregnancy centers are required to comply with the Bloodborne Pathogen Standard.

#### Latex Gloves

An OSHA interpretation which was issued in late 1993 stated that if latex gloves are used to comply with

the standard, employers must instruct their employees on their use and care. The training must include a prohibition against using petroleum or mineral lubricants with latex gloves. (Research has shown that latex gloves deteriorate when exposed to petroleum-based lubricants.)

#### Contaminated Sharps

The creator of a device for blunting needles after use, requested clarification from OSHA on its position on recapping and blunting. The Bloodborne Pathogen Standard paragraph (d)(2)(vii) prohibits the shearing or breaking of contaminated needles. The Standard states that needles should be used and immediately thrown away, unrecapped, into accessible sharps containers. The only exceptions would be when recapping is required by a specific medical procedure or if no alternative (such as immediate disposal into an appropriate sharps container) is feasible.

\*Taken from the *Bloodborne Pathogen Update*, David Hustvedt, Editor, 967 Poorman Road, Boulder, CO 80302, 800-334-1213.

### STDs In Colorado

Summary of the 1993 Colorado Department of Health Surveillance Report.

In 1993 the Colorado Department of Health compiled surveillance data and subsequently issued a report on four sexually transmitted diseases: chlamydia, gonorrhea, pelvic inflammatory disease and syphilis. A summary follows.

#### Chlamydia

Chlamydia is the most prevalent reportable condition in Colorado. In

1993, laboratories reported 7,198 positive tests, 80% of which were from females. Among females, the largest proportion of reported positive tests was attributed to the 15-19 year age group (44%); the 20-24 year age group comprised the second largest proportion (34%). Among males, the 20-24 year group comprised the largest proportion of reported positive tests (44%), followed by the 25-34 age group (25%) and the 15-19 age group (24%).

Chlamydia positivity rates are available primarily from family planning and adolescent clinics. These rates range from 3.6 to 10.8 percent for family planning clinics and 7.0 to 19.1 percent for adolescent clinics.

In 1994, data on demographic, clinical and risk factors will be collected from patients tested in Colorado family planning and STD clinics as part of a Centers for Disease Control and Prevention-funded six state regional chlamydia control project. Such data will yield a more meaningful assessment of chlamydia prevalence and more meaningful trends, which will facilitate the evaluation of chlamydia control activities.

#### Gonorrhea

Gonorrhea is a reportable condition in Colorado by both laboratories and health care providers. Reported incidents of gonorrhea have been decreasing since 1985, with two interruptions, one in 1988 and one in 1992. The 15-19 age group had the highest age-specific gonorrhea rate (525 per 100,000), closely followed by the 20-24 year age group (500 per 100,000). Among



males, the 20-24 year age group had the highest age-specific rate whereas, among females those aged 15-19 had the highest age-specific rate. Seventy-seven percent of the reported cases came from the five county Denver metro area. The positivity rate in the Denver area (175 per 100,000) was nearly three and a half times greater than the rest of the state (51 per 100,000). The overall gonorrhea rate in Colorado (113 per 100,000) is below the national year 2000 target (225 per 100,000); however the rate for African Americans (1534 per 100,000) exceeds that group's national year 2000 target (1300 per 100,000). Examples of the decreases in gonorrhea cases which were reported between 1992 and 1993 were: among males 23%, among females 14%, among African American 19% and among whites 18%. The number of reported cases among Latinos remained virtually unchanged.

## Pelvic Inflammatory Disease

Reliable data on reported incidence of pelvic inflammatory disease is not readily available, and therefore this report was based on data compiled on the 1992 hospitalization rate for PID. In 1992, an estimated 768 women aged 15-44 were hospitalized for PID in Colorado. The overall hospitalization rate was 94.6 per 100,000. The highest age-specific rate occurred in the 20-24 year age group (152 per 100,000). The fifteen to nineteen year old group had the second highest rate (117 per 100,000).

## Syphilis

In 1993, the number of reported

cases of early syphilis (ES) primary, secondary, and early latent syphilis) in Colorado increased 38% (160 cases) compared to 1992 (116 cases.), accelerating a trend that began in 1990. The greatest increases occurred among females, whites, the 25-34 and 35-44 year age groups and in the five county Denver-metro area.

Among whites, the number of reported cases of ES increased substantially in 1993, after decreasing from 1985 through 1993. Among African Americans, reported cases have steadily increased since 1990; reported cases of Latinos have stayed fairly constant since 1991.

In terms of gender and age group, reported cases of ES among females have increased in the 20-24 age group since 1991 and the 25-34 and 35-44 age groups since 1990. Among males, reported cases increased in the 20-24 year age group alone from 1989 through 1992, but increased in the 25-34 and 35-44 year age groups in 1993.

Reported cases of congenital syphilis (CS) also increased in 1993. Seven cases were reported in 1993 as compared with two in 1992. All seven cases were classified as presumptive CS based on the mothers having untreated or inadequately treated syphilis at delivery; two were syphilitic still births. Cases of CS almost always result from inadequate prenatal care.

Despite the aforementioned increases, Colorado's overall primary and secondary syphilis rate per 100,000 in 1993 (2.7) and rate for African Americans (32.2) were below the national year 2000 targets (10

per 100,000 overall and 65 per 100,000 for African Americans).

Syphilis surveillance data are compiled from reports submitted by health care providers and disease control specialists. Of the ES cases reported in 1993, 76% came from public providers, 19 % were from private providers and %5 were from the military.

## Getting married, again?

Perhaps you should consider ways to ensure your assets go to your children, or ensure you maintain full ownership of a house or business before you get married again. Find out what a pre-marital agreement can accomplish by calling Craig Fleishman, head of our Family Department.

## GELT, FLEISHMAN & STERLING P.C.

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**AURORA OPPORTUNITIES** - Immediate openings for Internists, Family Practitioners or General Practitioners in Aurora, Colorado. Excellent compensation, no call schedule, Monday-Friday 8:00 am to 4:30 pm, start-up bonus for full time physicians. Send CV to NES Government Services Inc., Attn: Lee Swinerton, 6477 College Park Square, Virginia Beach, VA 23464 or FAX to (804) 420-6616 or call (800) 637-3627 or (800) 283-5653. 3/594

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**COLORADO: Internal Medicine - BC/BE** - Group practice in southern Colorado seeks fourth Internist to share practice and call. Rural life-style, outdoor recreation, fishing and hunting opportunities. Loan repayment available. Call Dr. Michael Firth at 719-589-3658 or Marguerite Salazar 719-589-5161 or write to Valley-Wide Health Services, Inc., 204 Carson Avenue, Alamosa, CO 81101. 2/0494

**COLORADO: Family Practice - BC/BE** - Group practice in southern Colorado seeks new partner to join dynamic organization in caring for underserved population in outdoor wonderland. Loan repayment available. If interested in rural life-style, call Dr. Michael Firth at 719-589-3658 or Marguerite Salazar 719-589-5161. 2/0494

**INTERNAL MEDICINE-COLORADO SPRINGS:** 40 Physician multispecialty group seeking BC/BE Primary Care Internist. FFS/prepaid practice. Send CV: Administrator, Colorado Springs Medical Center, P.C. 209 S. Nevada Avenue, Colorado Springs, CO. 80903-1993. 3/0494

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**ESTABLISHED CHIROPRACTOR** with Sports medicine Center desires to share space with M.D. or D.O. provider for Sloans Lake, Travelers, some Met Life. Excellent DTC area (Bellevue and Yosemite) Please call Diane at 689-9778 or 770-4424. 12/0294

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## Medical/Dental Building for Lease 5730 Ward Road Arvada, CO

Ward Road health Center - a modern, attractive Medical Office Building. In high density residential area. Easy access and egress. Three suites are available; 1,129 sq. ft., 469 sq. ft. and 4,601 sq. ft. Suite diagrams and prices are available on request. Can accommodate an X-Ray Room. Call Richard A. Exley at (303) 220-0244, SNJ Equities, Inc. 2/0494

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**1500 sf Office in Medical condominium.** ideally located 3 Blks. from Lutheran hospital on 38th Ave. Sale or Lease. Could be used on time sharing basis (presently used by ophthalmologist 20 hrs. a week) or space could be divided with separate entrances. Ramp access for wheelchairs. Ample parking. Call (303) 237-8806.

3/0394

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**INNOVATIONS SHOULD BE PATENTED** if marketable. For more information call Brian D. Smith of Fields, Lewis, Pittenger & Rost. Colo's leading patent law firm. Mr. Smith specializes in the medical arts. (303) 758-8400. 12/1293

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## ◆ MISCELLANEOUS

**MENNINGER CONTINUING EDUCATION.** Depression throughout the Lifespan: Psychopharmacologic & Psychotherapeutic Strategies featuring Drs. Steven Dubovsky, Taylor Segreaves, George Zubenko, & Walter Menninger. June 24-25. Location: Kansas City. CE Credit: 12 hours. Cost: \$195. Contact: Menninger Continuing Education, 800/288-7377.

**DENVER:** PART TIME position for Associate Medical Director/Clinical Coordinator. Must be a licensed physician, with a Master's in Public Health, or a PhD in Epidemiology or Biostatistics, and at least five (5) years experience in direct patient care, and Board Certified in their specialty. An experienced physician responsible for directing and coordinating pattern analysis and feedback programs as well as the medical input for all CFMC activities related to the health information system and corporate planning division. Send résumé to: Employment Coordinator, Colorado Foundation for Medical Care, PO Box 17300, Denver, CO 80217-0300. 1/0394

**DENVER:** PART TIME position for clinical coordinator. Must be a PhD Epidemiology or Biostatistics. An experienced PhD responsible for directing and coordinating pattern analysis and feedback programs as well as the professional input for all CFMC activities related to the health information system and corporate planning division. Send résumé to: Employment Coordinator, Colorado Foundation for Medical Care, PO Box 17300, Denver, CO 80217-0300. 1/0394

**MEDICAL MARRIAGES:** Balancing Commitments to Family and Profession featuring Dr. Roy & Bev menninger. July 24-29. Crested Butte, CO. CE Credit: 24 hours. Contact: Menninger Continuing Education, 800/288-7377

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VIOLENCE**



**Check The Box  
On Your Colorado  
Tax Return**

**Domestic Abuse Assistance  
Programs Help Support**

- Prevention Programs
- Safe Homes
- Counseling
- Intervention





## RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

### **PRESIDENT'S LETTER.....**

**March 18, 1969**

**William M. Covode, MD**



*He was the President of Colorado Medical Society 1968-69 and was probably best known for his sense of humor and his ability to beguile. I'm almost certain that his patients were as captured by his charm as they were by his knowledge of medical science.*

*Members enjoyed his writings and, as a result, got his message more often than not.*

*This letter was printed just following the "Interim Session" of the CMS House of Delegates in March, 1969. As one CMS staff person pointed out when reading this, "the President...was concerned about political correctness and universal insurance coverage" even 25 years ago.*

*Issues don't change ...what changes is the presenter and the manner of presentation.*

*Dr. Bill Covode was an outstanding presenter.*

I am amazed at my own powers of perception. Last September in Colorado Springs I complained mildly of being elected to office without having declared a political platform and also of being left with the uncomfortable feeling that the necessary "51% following" could not be accounted for. Nothing in my experience of the first six months has done anything to comfort my apprehensions.

Some of my colleagues now refer to me as the "liberal" doctor. Generally, these are old friends who do not take me very seriously and are not in the least impressed by my high office — maybe a little surprised, but not impressed. They have other pet names for me that are more explicit and more carefully define certain physical characteristics I would prefer to forget. One good friend calls me "fat fellow", another "curly". This I have learned to live with.

On the other hand, the "liberal" doctor, as some of my colleagues announce it, seems to have an ominous tone, like the hushed announcement of the arrival of the French Delegation at a meeting of NATO.

The thing about this that worries me is the possible effect it may have on our future. It would be dangerous if I started to believe that I am the "liberal" doctor and that there was some compulsion to act accordingly in every situation. Not knowing exactly what the term means and what it implies in the way I react to events, I may become a little frenzied and irrational, even in commenting on things I am sup-

posed to have some real knowledge of. For instance: If someone were to ask me my ideas of hypertrophy of the prostate and I felt compelled to answer as a "liberal" what would I say? .

- "I think that it has definitely outlived its usefulness".
- "I have little sympathy for the disease that entirely ignores one sex".
- "It is all right for those who can afford it but we have to keep in mind that comprehensive care must include everyone".

These answers might satisfy some of the people some of the time....etc., etc., but even my more tolerant colleagues would begin to press for impeachment.

I think the time has come to give up on the "liberal" doctor thing until we all understand exactly what it means. I have no desire to be pushed into any extreme position. I am sure we would all rest more comfortably if I had a simple title such as "fat fellow" or "curly".

*(Dr. Covode's letter went on to urge members to attend CMS meetings on Medicaid, but his closing comments were typical.)*

A word on the Centennial Medallion -- The sale of these medallions will do a great deal to underwrite the imaginative plans that our committee has to celebrate the 100th year since the founding of the Colorado Medical Society. I strongly urge each of you to purchase one. I would suggest they be used as a challenge -- if you have one in your pocket and your colleague does not, he should pay for the drinks.

**Bill Covode, MD**

# Annual Meeting Golf Tournament

at Beaver Creek Golf Club  
Thursday, September 8, 1994  
Entry Form

ee times and emergencies

Home Phone \_\_\_\_\_ FAX# \_\_\_\_\_  
(Needed for tee times)

of (check one)  
itor ☐ Spouse ☐ Other  
le @\$100 ☐ Sponsor a putting green contest hole @\$50

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for sponsors. All proceeds will directly benefit the CMS Medical Indigence Program)

☐ USGA ☐ Other  
☐ Left handed ☐ Right handed

be arranged according to various levels of ability by the golf professional. If you  
h, please specify below. Prizes will be awarded for a variety of categories to include  
e tournament entry, registration form and advance payment of \$100 must be received  
received after August 28, 1994 are refundable subject to ability of Beaver Creek Golf

A shotgun start will not be possible, therefore, please be prompt with your tee times.  
all the Pro Shop at 303-949-7123.

ties, P. O. Box 36357, Denver, CO 80236. For additional information, call Tim

## ble during the 1994 Annual Meeting

e Hyatt Regency Beaver Creek. For more information, contact the hotel con-  
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### ADULT LANE SWIMMING

6 am-8 am and 5 pm-7 pm

ick boards and hand paddles available

Complimentary

### BADMINTON

k lawn. Rackets and birdies available at the Health Spa.

Complimentary

### HISTORIAN/STORYTELLER

Hyatt's resident historian/storyteller around the fire.

Complimentary

### HORSEBACK RIDING

7 years. Many options available. See reservation desk

ge rates \$18/hour-\$50/half day-\$90/Full day

### HOT AIR BALLOONS

Allow four hours. 6 am daily

\$190/person

See additional activity listings elsewhere in this issue.

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# COLORADO MEDICINE

June, 1994  
Volume 91, Number 6

## In This Issue...

Enjoy a great weekend in the outdoors with your family and accomplish the business of organized medicine at the same time.

The 124th Annual Meeting of the Colorado Medical Society is a great opportunity to demonstrate your commitment to the best interests of your patients by joining fellow medical professionals to formulate our corporate policies and actions for the coming year.

In addition, we have provided many varied activities for you to enjoy with your family, or for them to enjoy while you are in the meetings. Look inside for more information and register today!

## Activities Available during the 1994 Annual Meeting

*This information is provided by the Hyatt Regency Beaver Creek. For more information, contact the hotel concierge. All prices are subject to change*

**Hyatt Regency Beaver Creek**  
136 East Thomas Place  
Avon Colorado 81620  
(303) 949-1234  
FAX (303) 949-4164  
1-800-233-1234

### JEEP TOURS

Lunch Tour: \$55/Adult \$45/Child  
Three Hour Tour: \$45/Adult \$35/Child

### ALL TERRAIN VEHICLES

Two Hour Tour \$45/Adult  
(14 years of age and older)

### GUIDED FISHING

Float Fishing: 1/2 day - 8 am - 1 pm or 2 pm - 7 pm  
\$180/Boat (2 persons) Additional Persons @ \$40/each  
Shore Fishing. This is recommended for Groups

1/2 Day Trip: 8 am-1 pm or 2 pm-7 pm

Full Day Trip: 8 am-4 pm

1/2 Day (with snack)	\$100	\$150	\$200
Full day (with Lunch)	\$150	\$200	\$250

Note: Licenses are additional

### WHITEWATER RAFTING

Shoshone Rapids (Lower Colorado) (July-September): Open Class

3/4 Day Departs 9 am—Returns 2:30 pm—Snack  
\$60/Adult—\$55/Child

1/2 Day Departs 1:30 pm—Returns 7 pm—Snack  
\$50/Adult—\$45/Child

*See additional activity listings elsewhere in this issue.*



## Who's Looking at YOU, Doctor?

Colorado Medical Society  
1994 Annual Meeting Educational Program  
Saturday, September 10, 1994  
Hyatt Regency Beaver Creek, Avon, Colorado

## Who's Looking at You?

- |                     |   |
|---------------------|---|
| 7:00 am - 7:50 am   | Breakfast   |
| 7:50 am - 8:00 am   | Welcome/Introductions <b>David Martz, MD</b>  |
| 8:00 am - 9:10 am   | <b>Who's looking at you?</b><br>Presentations by representatives of the following to focus on the most useful piece of data each entity is collecting:                                      |
| -                   | Hospital QI   |
| -                   | Colorado Data Commission  |
| -                   | HCFA  |
| -                   | HMO   |
| -                   | National Practitioner Data Bank   |
| 9:10 am - 9:40 am   | Q/A — audience interaction with panel   |
| 9:40 am - 10:00 am  | Break   |
| 10:00 am - 10:40 am | <b>Coastal Crises</b><br>Physician-specific data <b>Warren Federgreen, MD, Florida</b><br>The reality of physician profiling/economic credentialing<br><b>Marie Kuffner, MD, California</b> |
| 10:40 am - 11:00 am | <b>The CMS Response</b><br><b>Tricia Byrns, MD, and Ned Calonge, MD</b>   |
| 11:00 am - 11:30 am | Q/A—audience interaction  |

## CMS Annual Meeting Golf Tournament

at Beaver Creek Golf Club  
Thursday, September 8, 1994  
Entry Form

Name \_\_\_\_\_

Address \_\_\_\_\_

*Please give us the following information for tee times and emergencies*

Office Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ FAX# \_\_\_\_\_  
(Needed for tee times)

While at Beaver Creek I will be staying at \_\_\_\_\_

I will be attending the meeting in the capacity of (check one)  
☐ Physician ☐ Exhibitor ☐ Spouse ☐ Other

I will: ☐ Sponsor a golf course hole @\$100 ☐ Sponsor a putting green contest hole @\$50

Name of sponsor (as you wish it to appear on sign) \_\_\_\_\_  
(Professionally made signs will be displayed for sponsors. All proceeds will directly benefit the CMS Medical Indigence Program)

My golf handicap is \_\_\_\_\_ ☐ USGA ☐ Other  
I will require rental clubs @ \$24 ☐ Left handed ☐ Right handed

Play will be scramble format. Foursomes will be arranged according to various levels of ability by the golf professional. If you have a preference of who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament entry, registration form and advance payment of \$100 must be received **no later than** August 16, 1994. Cancellations received after August 28, 1994 are refundable subject to ability of Beaver Creek Golf Club to "resell" vacated tee times.

You will be notified regarding tee times. A shotgun start will not be possible, therefore, please be prompt with your tee times. To reserve other personal tee times, please call the Pro Shop at 303-949-7123.

I prefer to be teamed with \_\_\_\_\_

Mail Entry Form and check to Media Specialties, P. O. Box 36357, Denver, CO 80236. For additional information, call Tim Jackson at 303-986-5926.

## Activities Available during the 1994 Annual Meeting

*This information is provided by the Hyatt Regency Beaver Creek. For more information, contact the hotel concierge. All prices are subject to change*

### ADULT LANE SWIMMING

6 am-8 am and 5 pm-7 pm

Kick boards and hand paddles available

Complimentary

### BADMINTON

Daily on the back lawn. Rackets and birdies available at the Health Spa.

Complimentary

### HISTORIAN/STORYTELLER

Tales from the Hyatt's resident historian/storyteller around the fire.

Complimentary

### HORSEBACK RIDING

Minimum age, 7 years. Many options available. See reservation desk

Average rates \$18/hour-\$50/half day-\$90/Full day

### HOT AIR BALLOONS

Allow four hours. 6 am daily

\$190/person

*See additional activity listings elsewhere in this issue.*

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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Michael Thompson, Asst. Managing Editor; Gil Maestas, II, Communications Specialist



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## Call For Nominations

1994

Colorado Medical Society

## Certificate of Service Award

The Certificate of Service is the highest award given by Colorado Medical Society in recognition of a physician's outstanding contribution to the constitutional purposes of the Society.

Deadline for receipt of nominations for the 1994 Colorado Medical Society Certificate of Service Award is July 15, 1994. Nominations should be made by letter.

## Call For Nominations

### *A. H. Robins Award*

Presented by the Wyeth-Ayerst  
Laboratories

### 1994 Physician Award for Community Service

Criteria for this award are as follows:

1. The recipient must be a physician, licensed within the state of Colorado.
2. The recipient must be living. Awards will not be presented posthumously.
3. The recipient has not been a previous recipient of the award.
4. The recipient has compiled an outstanding record of community service which, apart from his/her specific identification as a physician, reflects well on the profession.

The Colorado Medical Society Certificate of Service Award and the A.H. Robins Award will be presented at the 1994 **Annual Meeting, September 9-11, 1994**, at Beaver Creek, Colorado.

Deadline for receipt of nominations is July 15, 1994.

Nominations for both awards (with supporting information) should be sent to the **Confidential Awards Committee, Colorado Medical Society, PO Box 17550, Denver, CO 80217-0550**

## THE 120 DAY

JUN 17 1994

NEWSLETTER  
REC'D NOT IN CIRC.

STACKS

from the COLORADO MEDICAL SOCIETY

A complete legislative summary at the close of the 59th General Assembly

June 1, 1994

STACKS

59th General Assembly:  
- - Looking Back*by Frederick A. Lewis, Jr., M.D., Chairman  
CMS Council on Legislation*

This has been written as the legislature has drawn another session to a close. All in all, CMS has done well. The bills we supported have tended to be passed and the bills we opposed have tended to be defeated. Most of the amendments we have proposed have been accepted. Our batting average is not 100%. We have not won all of the battles but, generally, we have been more successful than we could have predicted in January. The credit goes to our legislative working team, which has performed in an outstanding manner.

Ultimately, however, the legislative process may turn out to be almost as important as the outcome. There have been several disturbing trends during this year's legislative session. Probably the most distressing event has been the obvious fragmentation within the ranks of organized medicine. This article is written in the hopes of obtaining some feedback from one of you who belong to the various branches of organized medicine. It seems apparent that these organizations will not present a united front unless directed to do so by their membership. The CMS and the various specialty organizations in Colorado do need to hear from its membership, i.e., you.

As an example, HB 1186 (discussed at length in this column last month), was opposed by CMS, primarily because we felt that it would tend to fragment medicine. The bill was passed in House Appropriations. For those of you who do not know, this bill contained a long definition of "primary health care provider" which tended to exclude all physicians who did not have a three year residency in family medicine. It also included a definition of "primary mental health care provider" which was offensive to many physicians. After some unsuccessful attempts to work with the Colorado Academy of Family Practice, CMS decided to oppose the bill and we were successful.

Toward the end of the legislative session, the following legislative resolution was introduced and passed. It does not require much imagination to suspect that the CAFP had a hand in drafting it. From a practical point of view, its passage does not mean a great deal but it is deeply symbolic of the chasms which currently split medicine. I am interested in your response and will outline my own reaction after you have had the opportunity to read the resolution for yourself.

**WHEREAS**, Family physicians are the key to better, more efficient, and less costly health care; and

**WHEREAS**, Family physicians provide health care to all segments of the population; and

**WHEREAS**, Family physicians respond to 80-95% of the medical problems presented to them; and

**WHEREAS**, Most physicians in rural areas are family physicians; and

**WHEREAS**, All health care reform proposals share in common a call for more family physicians in order to provide cost-effective managed care statewide for the citizens of Colorado; and

**WHEREAS**, The Commission of Family Medicine, in section 25-1-903, Colorado Revised Statutes, is charged with identifying specific areas of the state that are undeserved by family physicians and determining the priority of needs among such areas; now, therefore,

**BE IT RESOLVED** by the Senate of the Fifty-ninth General Assembly of the State of Colorado, The House of Representatives concurring herein:

That we, the members of the Fifty-ninth General Assembly, hereby request the Commission of Family Medicine to direct a detailed study, at no cost to the state, on the current and anticipated need for family physicians in the state of Colorado and report its findings to the General Assembly no later than June 30, 1995.

Looking back over the past 40 years, I would agree completely that primary care physicians have generally been treated unjustly by society. They have worked long hours, have been inadequately compensated, and have tended not to be accorded the same prestige which most physicians have enjoyed. I can understand why they may be genuinely convinced that they have gotten the short end of the stick. In fact, they probably have and I for one, think that organized medicine has an obligation to attempt to rectify these past societal discriminations.

However, I do not feel that these past societal errors justify an attempt on the part of primary care physicians to re-

(Continued on next page)



(Continued from preceding page)

structure the practice of medicine in a manner that will allow them to retaliate against the rest of medicine at the expense or the welfare of patients. Neither do I think that the governmentally perceived "shortage" of primary care physicians should be solved by bureaucratic regulation which prevents young physicians from being able to freely select residency programs in the same manner that you and I did.

I have absolutely no objection to the final resolve but, in terms of the "WHEREAS", there is simply no way that many of these statements can be substantiated from an objective point of view. Primary care physicians simply can not be differentiated from other physicians by being: "better, more efficient, serving a broader segment of the population, responding to a higher percentage of the medical problems presented to them", or as being "capable of providing more cost-effective health care".

Family physicians probably can offer less expensive care to more people with some corresponding sacrifice in quality of care in key areas. (Less expensive is not the same thing as cost effective.) I have the uneasy feeling that some family physicians are being co-opted by some politicians. What do you think?

This is an issue which is not going to go away. Unless resolved, it will continue to fragment the legislative approach on the part of all of medicine. At this point, each organization needs to touch home base and get some input from its constituents.

## Medicaid's mandatory Electronic Funds Transfer (EFT) program

In the May, 1994 issue of Colorado Medicine, two stories ran regarding the Medicaid's mandatory Electronic Funds Transfer (EFT) program (*Executive Director's Update - Social Services EFT Directive for Medicaid Physicians*, page 173 and *Medicaid [The Most Recent Flurry of Attention]*, page 178). The stories discussed the status of the EFT program and outlined CMS' concerns with it.

On Friday, May 6, 1994 CMS offered testimony to the Colorado State Board of Social Services outlining physician concerns with the mandatory EFT program. The Board was very receptive to the physician concerns presented, and, realizing the devastation the Medicaid program could face if physicians opted out of the Medicaid program over the EFT issue, removed all reference to the EFT program from its rules.

CMS then met on Wednesday, May 11, 1994 with the Department of Social Services to discuss the, now voluntary, EFT program. There are four options available to physicians who treat Medicaid patients:

1. Physicians who signed the original form and remain comfortable with that decision will begin receiving EFTs on June 10, 1994.
2. Physicians who signed the original form and are uncomfortable with the language about debits and credits to their accounts have the option of signing a new, more explanatory form, and can begin receiving EFTs on June 10, 1994.
3. Physicians who signed the original form and are uncomfortable

with giving Medicaid access to their accounts can retract the signed form and continue to receive Medicaid payments via paper check.

4. Physicians who refused to sign the original form and want to sign the new, more explanatory form, can continue, business as usual, receiving payment via paper check.

All of this information, including who to contact concerning the option each physician chooses, will be sent to Medicaid providers via enclosures in an upcoming remittance statement. The information will also be available at CMS.

## Medicaid Abortions

U.S. District Judge Edward Nottingham recently ruled that Colorado's law permitting Medicaid-funded abortion when the woman's life is in danger violates federal regulation that requires Medicaid funding for abortions resulting from rape or incest as well. The Department of Social Services has filed a request for a stay of execution from the 10th U.S. Circuit Court of Appeals. A ruling is expected in approximately two weeks.

Physicians should be aware that if the stay is granted and the decision of Judge Nottingham is overturned, or if the Colorado Department of Social Services chooses to withdraw from the federal Medicaid program until the issue can be brought before the voters and the voters defeat the inclusion of abortions resulting from rape or incest, none of the abortions performed in the interim will be covered by the Medicaid program. Physicians should proceed in performing these abortions with the understanding that final ruling on coverage remains indeterminate.

## Rules and Regulations regarding education and training standards for unlicensed personnel exposing ionizing radiation

In keeping with the directive of the General Assembly, the Colorado Board of Medical Examiners (BME) has determined that contribution to public protection can be achieved by requiring persons, not possessing a medical license, who operate machine sources of ionizing radiation or who administer such radiation to patients for diagnostic medical use to demonstrate competency via satisfactory passage of the limited scope examination.

The exam was initially to be administered by the American Registry of Radiologic Technologists ("ARRT"), however it has become necessary for the BME to revisit this issue at the July Board meeting. The effective date may be moved back from its current July 1, 1995 date. The outcome of the meeting will be reported to the CMS membership via *Colorado Medicine*.

## 15 Legislative Wrapup

*Lorraine Koehn, Director  
Suzanne Hamilton, Program Manager  
CMS Department of Government Relations*

Thank you CMS for providing us the opportunity to work in a profession which we love! Special thanks also to our Leadership, our Executive Director, Sandi Maloney, Council on Legislation Chairman, Fred Lewis and members of the Council plus all those who took time from their practices to testify at the Capitol! We consider this to be one of the more successful legislative years for CMS but the frenzied activity of 120 days at the state legislature does take its toll and we're always relieved in the final gavel sounds.

We're grateful that we have added to our lobbying team a new contract with Colorado Legislative Services to support our lobbying efforts. This group brings to us four of the best and most respected lobbyists in Colorado. Jerry Johnson, Bonnie Geiger, James Cole and Cathy Walsh have offices just across the street from the Capitol and CMS has mainly benefited from their expertise and hard work. The Council on Legislation prioritized 61 legislative proposals in 1994 and a listing of those bills and their priority status follows this article which offers a brief description of the high priority issues. We urge you to contact our department (779-5455 or 1-800-654-5653, Ext. 427) for information on any of the bills listed on the priority list or a copy of the CMS Legislative Digest which fully describes all the measures followed by CMS.

**SB 199, Concerning Workers' Compensation (Norton):** This bill was introduced late in the session and represented a compromise between the business and labor communities regarding amendments to SB 218 ('91). CMS opposed an extension to the fee freeze contained in the bill and the fact that the section allowing the Division to remove a provider from the system did not contain an appeals mechanism. A compromise was reached during the last 48 hours of the session - the appeals mechanism was inserted into the bill and the fee freeze will be extended until July 1, 1995. The bill passed with our compromise language.

**HB 1022, Naturopathic Health Care Practice Act (Foster):** Our lives were made easier when this bill was passed in the House Health, Environment, Welfare & Institutions (HEWI) Committee early in the session. CMS opposed this request for licensure because it would have allowed naturopaths to (1) serve as primary care physicians and prescribe "naturally based" substances (including opium, morphine, codeine, digitalis, estrogens, lithium, prednisone, etc.); (2) perform "minor office procedures" (including suturing, lacerations, electrical or other methods for the surgical repair of wounds, and the use of antiseptics and local anesthetics); (3) practice naturopathic childbirth with a certificate of specialty practice.

The naturopaths have made application to the 1994 Legislative Sunrise/Sunset Committee for approval of a

similar proposal in 1995.

**HB 1081, Regulation of the Advanced Practice of Nursing (Entz):** Allows for establishment of a registry of licensed nurses who have obtained specialized education. CMS opposed a section of the bill which we believe may have provided blanket prescriptive authority for advanced practice nurses. This section was amended out of the bill which now allows the Board of Nursing to establish standards for persons who register as advanced practice nurses. The bill passed with our amendments.

**HB 1136, Prohibition of Smoking in State Buildings (Kreutz):** Prior to the introduction of this bill, Governor Romer declared all state buildings and the first floor of the capitol "smoke free" but smoking has been permitted in the cafeteria area located in the basement of the capitol and on the second and third floors. The bill, as passed, requires that all state buildings be smoke-free but does contain a clause which allows the State Legislative Council to make exceptions to this law. We will be working with members of the Council to assure that any excepted area is well-ventilated.

**HB 1186, Measures to Enhance Cost Containment in the Health Care System (Prinster):** One of three bills in a package of proposals aimed at Colorado health care reform. The other bills are HB 1193 and HB 1210. CMS voiced serious concerns regarding the section which dealt with the definition of a primary care physician - we do not believe that such a definition should be placed in statute. The bill was killed in House Appropriations Committee.

**HB 1193, Concerning Health Care Coverage Purchasing Arrangements and Authorizes the Creation of Health Care Coverage Cooperatives and Provider Networks (Foster):** Sets forth mechanisms for the creation of health care coverage cooperatives and provider networks. It establishes procedures for the organization and dissolution of such cooperatives and provider networks. CMS did not oppose HB 1193 but voiced our concerns that (1) we support employee ownership and choice of policies; (2) insurance reform would be the preferred alternative, and (3) we have reservations concerning the cost effectiveness of this bill which passed during the final days of the session.

**HB 1210, Measures to Improve the System of Financing Health Care Costs Using Arrangements With Private Third-Party Payers (Coffman):** The bill requires individual and small employer carriers doing business in the state to offer at least the basic and standard health benefit plans coverages which are being proposed by the Cost Containment and Guaranteed Access Commission. CMS supported this proposal which limits the preexisting conditions clauses contained in many policies and provides for portability of coverage when employees change jobs. HB 1210 passed.

**HB 1231, Regulation of Emergency Medical Services (Tanner):** The CMS opposed this bill which we believed placed costly restrictions on the provision of emergency medical services. The bill was killed in House HEWI Committee.

**HB 1300, Concerning the Board of Medical Examiners**

*(Continued on next page)*



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**(Pierson):** The CMS attempted to work with the sponsor and the proponents of this bill to address their concerns and yet assure due process for physicians when complaints are filed against them. The proponents of the bill were a small group of consumers whose family members died because of what the proponents believed was substandard medical care. This group believes that all **complaints** against physicians should be a matter of public record and they have assured us that they will continue their efforts to gain access to all **complaints** filed with the BME. The bill was killed in House Appropriations but we will be faced with this issue again this summer when the Medical Practice Act is up for review.

**HB 1342, Minimum Mandatory Automobile Insurance Coverages (Epps):** This bill would have greatly reduced the amount of coverage for liability, medical, and rehabilitative expenses currently required under Colorado no-fault automobile statutes. CMS opposed the measure which lost on second reading in the House.

Yes, this year's legislative efforts were a success, but

we're already looking at the challenges we will be facing during the 1995 legislative session. We wish there was a magic wand that we could use to force you to understand the importance of each of you developing a working relationship with just one legislator. During the summer the Legislative Sunrise/Sunset Committee will be reviewing the practice acts of chiropractors, nurses, pharmacists and podiatrists as well as the Medical Practice Act. It is expected that most of these groups will be attempting to expand their scope of practice and the only way we will be able to counteract these efforts is for YOU to become involved! It continues to amaze us how very little our legislators know about the practice of medicine. The chiropractors, nurses, optometrists, podiatrists and trial lawyers have achieved victory in the past because they were there when truly needed - during a candidate's campaign. **Don't procrastinate one more moment - give us a call, tell us where you live and we'll help you become acquainted with a candidate in your area.**

## CMS LEGISLATIVE PRIORITIES

Sine Die

**Legend:** Lost - Defeated on 2nd Reading; Pl'ed - Postponed Indefinitely

### SUPPORT

Bill #	Title	Status
<b>High Priority</b>		
HB 1081	Advanced Practice Nursing	Passed
HB 1136	Prohibit Smoking in State Bldgs.	Passed
HB 1193	Health Care Coverage Cooperatives	Passed
HB 1210	Insurance Reform	Passed

### OPPOSE

Bill #	Title	Status
SB 199	Workers' Comp. (Unless Amended)	Amended/Passed
HB 1022	Naturopaths	Pl'ed
HB 1231	Emergency Services	Pl'ed
HB 1186	Cost Containment	Pl'ed
HB 1300	Consumer BME (Unless Amended)	Pl'ed
HB 1342	Minimum Mandatory Auto Ins Coverage	Pl'ed

### SUPPORT

Bill #	Title	Status
<b>Moderate Priority</b>		
SB 58	Genetic Testing	Passed
SB 77	Child Health Ins. Reform	Pl'ed
SB 93	BME Functions	Passed
SB 100	Prohibit Tobacco in Schools	Passed
SB 128	UHICO	Pl'ed
SB 183	Protective Helmets for Specified Ages	Pl'ed
SB 211	Poison Control	Passed
HB 1047	Motorcycle Helmets	Pl'ed
HB 1058	Medical Savings Accounts	Passed
HB 1219	Peer Review	Passed

### OPPOSE

Bill #	Title	Status
<b>Moderate Priority (Continued)</b>		
HB 1209	CO Auto Accident Reparations Act (Unless Amended)	Amended/Passed

### SUPPORT

Bill #	Title	Status
<b>Low Priority</b>		
SB 67	Clinical Trials for Cancer	Pl'ed
SB 99	Denver Health & Hosp. Authority	Passed
SB103	Trauma Systems	Passed
SB 110	Nursing Home Reimbursement	Passed
SB 111	Child Welfare Amendments	Passed
SB 142	Patient Autonomy	Passed
HB 1016	Respiratory Care Practice Act	Pl'ed
HB 1060	W/C Medical Treatment	Pl'ed
HB 1078	Newborn Screening	Passed
HB 1094	Catastrophic Health Insurance	Passed
HB 1102	Dietitians	Passed
HB 1115	Uncompensated Health Care	Pl'ed
HB 1140	Managed Health Care Org.	Pl'ed
HB 1146	PT's Wound Debridement	Passed
HB 1154	W/C Non-physician Comp.	Pl'ed
HB 1179	Alzheimer Drivers Restrictions	Pl'ed
HB 1253	Reducing Domestic Violence	Passed
HB 1277	Deterrents to Litigation	Pl'ed

## OPPOSE

#	Title	Status
1	Priority (Continued)	
11	W/C IME's	Pl'ed
10	Services by Psychotherapists	Pl'ed
#	Title	Status
1	Monitor Only	
2	MI Health Care	Passed
4	Public Health Related Sunset Dates	Passed
9	W/C Motor Vehicle Accidents	Passed
9	Medical Assistance Act Amendments	Passed
9	Consumers - Prescriptive Drugs	Vetoed
1	Limited Liability Companies	Passed
1	Violating Nursing Facility Standards	Passed
1	Dept. Health Care Policy & Financing	Passed

Bill #	Title	Status
Monitor Only (Continued)		
SB 205	Delivery of Social Services to Families	Passed
HB 1035	Certify EMS Dispatchers	Pl'ed
HB 1051	Prosthetics in WC Cases	Passed
HB 1106	Peer Health Assistance	Passed
HB 1129	W/C Benefits Cessation	Pl'ed
HB 1134	Health Care Coverage Entities	Pl'ed
HB 1185	Essential Providers Health Care	Passed
HB 1195	W/C Medical Treatment	Passed
HB 1205	Combine Health Insurance Programs	Pl'ed
HB 1250	Undocumented Employee	Lost
HB 1266	Deductibles in W/C Ins.	Passed
HB 1303	Medicaid Managed Care	Lost

## COMPAC Update

Robert Sawyer, MD, Chairman

The Colorado Medical Political Action Committee (COMPAC) is a bipartisan committee dedicated to electing candidates and to listen to the concerns of the medical community. COMPAC membership currently totals 458 members - less than half of the CMS membership. Total contributions stand at \$30,750 which will allow us to contribute only \$380 per race based on the expected 81 races in the general election! That's certainly not very impressive when you consider the magnitude of the issues we expect to confront during the 1995 legislative session.

Legislative races are expensive and few candidates have the personal funds available to conduct a successful campaign. Campaigns range from \$20,000 in the State House of Representatives to \$98,000 in the State Senate. Even those candidates who are unopposed need funds to finance communications with their constituents. Your COMPAC Board of Directors is pleading with you to join COMPAC now - you need only to issue your check, complete the following form and forward it to COMPAC, PO Box 17550, Denver, CO 80217-0550.

## Membership

### COMPAC (Colorado Medical Political Action Committee)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

#### Membership Categories

(Check One)

- |                                     |         |
|-------------------------------------|---------|
| <input type="checkbox"/> Sustaining | \$99.00 |
| <input type="checkbox"/> Alliance   | \$40.00 |
| <input type="checkbox"/> Resident   | \$15.00 |
| <input type="checkbox"/> Student    | \$ 5.00 |

COMPAC is a separate segregated fund established by the Colorado Medical Society. Voluntary political contributions by individuals to COMPAC should be written on personal checks; corporate contributions can be used only for state legislative elections. Contributions are not limited to the suggested amount. Neither COMPAC nor its AMA affiliate, AMPAC (American Medical Political Action Committee) will favor or disadvantage anyone based upon the amounts of, or the failure to make PAC contributions. Voluntary political contributions are subject to the regulations of FEC Regulations, Section 110.1, 110.2 and 110.5 (Federal regulations require this notice). A portion of your contribution will be forwarded to AMPAC to support candidates in Federal elections.

Please Detach and Forward With Your Contribution to: COMPAC, PO Box 17550, Denver, CO 80217-0550

Contributions to COMPAC and AMPAC are **not deductible** as charitable contributions for Federal income tax purposes.



# A physician-controlled managed care organization?

*Following are comments made to the El Paso County Medical Society on May 11, 1994 by Dr. John Farrington, chair of the CMS Network Task Force, regarding the Colorado Medical Society's consideration of sponsoring a statewide physician-controlled managed care organization.*

## The only way one can predict the future is to create it.

The major point we must address in any health care reform proposal is not money, it is who will be responsible for clinical decision making responsibilities. The fight will be to keep this professional function within the purview of our profession and not relinquish it to phantom insurance administrators or bureaucrats.

We must accept two facts. 1.) The question is no longer "Will there be health care reform?" but instead, "What form will it take?" Even without government meddling, health care delivery and financing will continue under pressure from those who pay for it. A major question we must answer is will organized medicine be a partner in initiating rational change. 2.) The second fact is that physicians are the essential ingredient in any health care system. The reformers need us, our medical expertise and our ideas.

Under the leadership of Leigh Truitt, M.D., the Colorado Medical Society (CMS) began to explore the development of a statewide IPA or other physician-controlled managed care organization. The IPA Task Force created by a resolution adopted at the 1993 annual meeting has been renamed the Network Task Force to more accurately reflect its charge. After a good deal of preliminary work we are in the final stages of developing a member survey. The goal of the survey is to determine whether the members of CMS believe that sponsoring a statewide physician network to contract with a variety of managed health care organizations or creating our own managed health care organization would be viable approaches to dealing with the rapidly changing health care financing and delivery environment.

The survey will be conducted by Monaghan and Associates, a Denver-based research and strategy firm, and will be sent to a statistically significant sample of CMS members that will take into consideration both geographic and specialty distribution. If you are asked to participate in the survey please respond affirmatively.

I'm not here to give you the hard sell. If the membership of CMS indicates a lack of support, so be it. If there is support for the idea then sufficient resources will be allocated to do the job properly. This may be likened to the development of COPIC.

I am certain that all of you have existing arrangements with a variety of managed care organizations or hospital sponsored groups. It is not the purpose of CMS to disrupt any of these relationships. I believe it would be best to use these existing arrangements to build on when possible.

The task force has not made a recommendation regarding the legal structure for this organization. We have discussed the concepts of forming an IPA, PPO, HMO, PC, clinic without walls or a cooperative. The legal structure

will depend on what CMS membership wants to accomplish.

If approved by the membership I would hope that this would be only one prong of a physician led campaign to improve the health care system in Colorado. The other prong would be for the state medical society and other interested groups to develop a bill for introduction before the 1995 legislature that would clearly state what we are in favor of rather than having to always be in the position of having to argue what we are opposed to.

Remember, if health care reform is to work it must be comprehensive. We must identify the universe of problems that contributed to this problem and work toward solving them.

Addressing the CMS proposal let me pose several business questions:

1. Does the membership of CMS want to band together to form a statewide organization to influence the course medicine will take?
2. Are you, the members of CMS, willing to support such an organization, not only financially but also functionally?
3. Will you adhere to the rules you set up to guide this organization?

If the answer to these three questions is yes then another series of questions will evolve.

1. Are you prepared to identify what management functions this organization can undertake?
2. Are you willing to actively manage the physician group?
3. Are you willing to perform aggressive quality assurance, utilization review and either educate or weed out non cost effective physicians?
4. Can this organization gain credibility with physicians, patients, payers, employers and government?
5. What are the chances of success?
6. Can physician loyalty be developed?
7. How will the organization be financed?
8. Can CMS identify the leadership to do it?
9. Can leaders be identified who will have the time to do it right?
10. Does the membership have the commitment to do it over the long haul?

Experience with other physician groups in Colorado would indicate that this can be done in a cost effective way that benefits both patients and physicians.

## Steps to Success

1. Develop bylaws and policies that define what you want to do - IPA, PC, clinic without walls, etc. **Then stick to them.**
2. Have a yearly planning session to develop and keep your business plan updated.

(Continued on next page)

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Remember you are creating a Service organization. Make certain your physician group is divided into groups of a manageable size, probably on a geographic basis, making certain that the management tools are the same for each group.

Decide on your contracting philosophy. Are you willing to enter risk or capitation contracts? Will you sign anything for fear that someone else will get the business?

Start out with a data system in place that will provide all of the functions that are needed.

#### Most Important

Claims input

Repricing

Electronic Data Interchange

Quality Assurance/Utilization Management

Membership Information

Directory

Bookkeeping

Mailing

Provide a single phone number for physicians to obtain pre certification and prior authorization by phone or FAX.

Decide on your credentialing/recredentialing functions.

Be user friendly and supportive.

Most importantly, recognize that you are running a business.

#### Challenges We Face:

It can be done but the window of opportunity is small and is rapidly closing.

The antitrust implications of a large physician group dominating a service area must be clarified.

The development of the concept need not be prohibitively expensive. We have the minds in CMS to get the job done. This does not imply that it won't cost anything but it can be done for a reasonable cost.

The most important things are to decide if you want to and then make the commitment to do it right.

Project your mind over the horizon. Keep an eye on future and not on the past.

## Free Immunization Clinics To Be Held In the Denver-Metro Area

The Metro Denver Immunization Campaign is providing the following **free** immunization clinics.

9 a.m. to 3 p.m.

Saturday, June 4

Shorter AME Church/3050 Richard Allen Ct., Denver

Saturday, August 27

Lake Middle School/1820 Lowell Blvd., Denver

Saturday, Sept. 24

Kunsmiller Middle School/Southwest Community School/2250 S. Quitman Way, Denver

Saturday, Oct. 15

Faith Lutheran Church/17701 W. 16th Ave., Golden

Saturday, Nov. 5

Career Enrichment Park/7300 Lowell Blvd., Westminster

Children must be accompanied by a parent or legal guardian. Please ask parents to bring the child's up-to-date shot record to the clinic.

Parents interested in more information about these and other immunization clinics can call the Family Healthline at 692-2229; outside Denver call 1-800-688-7777. The Healthline is offered in both Spanish and English.

The Metro Denver Infant Immunization Campaign is composed of representatives from the following organizations: Rotary Clubs of Colorado, Denver Health and Hospitals, Tri-County Department of Health (Adams, Arapahoe, Douglas), Jefferson County Department of Health and Environment, National Association of Pediatric Nurse Associates and Practitioners/Colorado Rocky Mountain Chapter, The Children's Hospital, The Colorado Children's Immunization Coalition, Merck Vaccine Division

## Why?

**The 120 Day Newsletter** is published this year to supply physician members with the latest news and information. The June issue of **Colorado Medicine** magazine is (of recent tradition) devoted each year to the September Annual Meeting of the House of Delegates. Therefore, we need a news medium, and the **Newsletter** is the format we've chosen.

The General Assembly just quit (sine die) on May 11th and there was (as you can see from the Legislative Summary included herein) a lot of medical business on their plates. Whether it was all consumed, eschewed or set aside is the important aspect of adjournment. We'll try to fill you in with this newsletter.

There are also other important regulatory news items which needed to be put before you. Whatever space we have left is devoted to other news summaries.

None of this is designed to take the place of **Colorado Medicine** and will not be published in any month other than June.



## Federal Legislation

On May 23, the AMA introduced the **Patient Protection Act** - legislation designed to ensure that health care treatment decisions are made by patients and physicians, not insurance companies.

The insurance industry responded immediately with a massive campaign against the **Patient Protection Act**. AMA Washington staff report intense lobbying by the Big Five - Aetna, Cigna, MetLife, Prudential and Travelers - to defeat the proposal.

You may contact your CMS Department of Government Relations for additional details on the Patient Protection Act. Staff will also advise you of the name of your Colorado Congressman so you can draft a personal letter regarding this proposed Act.

Physicians and patients can also send their U. S. senators and representative a message by calling 1-800-592-9292 and urging Congressional members to support the act. The operator will make sure the correct members of Congress are contacted. The charge is \$8.25 for three messages, and can be charged to a telephone number, MasterCard or Visa.

## Announcement

The Colorado Department of Labor and Employment, Division of Workers' Compensation, will present the 1994 Level II Physician Accreditation Seminar on Friday and Saturday, July 22-23 at the Stapleton Plaza Hotel, 3333 Quebec Street in Denver. The Level II Seminar is a series of lectures and workshops led by experts in the administrative and legal aspects of the workers' compensation system. In addition, the Level II Seminar will educate physicians on how to formulate impairment ratings utilizing the American Medical Association Guides to the Evaluation of Permanent Impairment, 3rd Edition Revised.

For more information, contact Faye Boyd, Accreditation Coordinator, at 303/764-4355.

## COLORADO MEDICAL SOCIETY

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Volume 91, Number 7

AUG 4 1994

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REC'D NOT IN CIRC.

While Colorado Medical Society attempts to help the state's rural physicians, are we just

***"Tilting at Windmills?"***

See Page 222:

***"Rural Health - major topic of discussion for CMS Task Force"***

Also in this issue:

- **Commencement, 1994**  
Wm. Carl Bailey, MD  
CMS President
- **The Power of One**  
Paul G. Becker, MD  
Denver, Colorado
- **Information YOU need for the upcoming Annual Meeting**

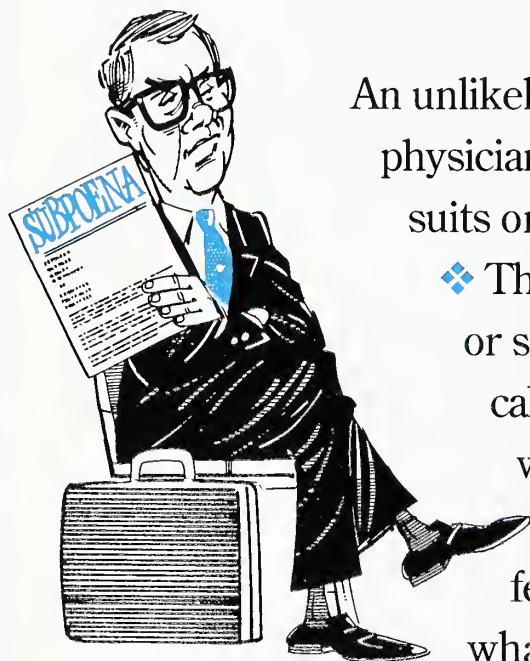


University of Maryland  
111 S Greene St  
Baltimore MD 21201-1583

BALTIMORE



# 'Doctor, Doctor! Come Quick! There's a Process Server in the Waiting Room!'



An unlikely scenario? Unfortunately, no. Colorado physicians are on the receiving end of malpractice suits on the average of once every seven years.

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# COLORADO MEDICINE

July, 1994

Volume 91, Number 7



## Cover Story

Don Quixote never saw a cattle tank in Colorado, but many of our state's physicians have. A CMS Task Force is vitally interested in the problems and successes of these physicians. See page 222.



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# COLORADO MEDICAL SOCIETY

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# Computer Talk

Medical Practice Automation Issues & Information

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## The Big Picture; Turning Data Into Information

A computer system stores, manipulates and retrieves data. How we command it to perform these functions determines how useful that data becomes. When we arrange *data* into meaningful order, it becomes *information*.

But even the most important information is of very little value if we don't put it to use. Since information (knowledge) is power, you might even say that the information your system provides adds as much or more power as a new CPU. It's just a different kind of power.

Unfortunately, there are still many physicians and managers who don't know how to get meaning out of the many reports their system produces. In many systems, generating reports is an automatic process, occurring simultaneously with month end closing procedures. But in the scramble to get a new system up and running, the interpretation of these reports is either omitted during training, or not adequately absorbed or understood. As a result, important reports simply pile up month after month (or are not printed at all), and their value goes unappreciated.

There is a strategy you can employ that will help you get to the meaning of your system's reports quickly and effectively.

Start with *summary* information first. This is most commonly found at either the beginning or end of a report. Or it may be in a report all by itself.

Compare this summary data to last month's (or any period's) reports. Look for anomalies and trends. When you see something deserving of attention, zoom in on the *detail* in the report itself to find out

more.

For example, let's say you are looking at an A/R aging report. In the summary columns at the end of the report, you notice your bottom line at 90 days is swelling. Every month for the last three months it has gotten bigger. At 120 days and further, it goes down again to normal levels. What's going on?

Now you turn to the same data sorted by account type (sometimes called category, financial class, etc.) Here you notice that the 90-day swelling is caused by the type of accounts that represents your PPO's. Now, zeroing in on *only* the aging of your PPO's you spot the problem: A new PPO you signed up with six months ago seems to take forever to pay claims. Now you have a starting point at which to work from.

You may be surprised to find there is something your office is doing that causes delays in that company's processing cycle. Since this is something the PPO may not be entirely anxious to straighten out, you may never have noticed the problem.

And you would probably have missed the problem entirely if you had started with the detail, endlessly pouring over individual patient accounts. You probably wouldn't have been able to see the forest for the trees.

Another example might involve your monthly A/R totals. Suppose you compare the total deposits (payments posted) for the last few months and you notice a drop in one month. When you compare production (charges posted) in the previous months there is no corresponding drop. It would appear you're working just as much, but not

being paid for it.

Next you look at a report that sorts your payments by account type. You notice the drop has occurred in the PPO category.

Again, you zero in on payments for just the PPO's. Here you discover that new PPO. These accounts are not being reduced by payments and adjustments at the same rate as the others. In this case, we have simply used a different set of reports to uncover the same problem, namely that new, slow-paying PPO.

But what if your system's standard reports don't give you the information you need? Many systems today include (often as an optional module) a custom report generator.

The problem with these tools is that they are often a bear to use. Even after training, your staff may not be able to use them with any real confidence. You may find you still have to pay your vendor for custom reports - even though you purchased your own report generator.

It's important to take a close look at these report generators during the computer selection process. Talk to other users to see how practical yours will be. How many users use it and how often? Can your staff use it?

But if you can readily generate custom reports, it can be a real boon. It just may be important for you to know what the highest and lowest payment for a particular procedure is, and from whom, before you sign that new PPO contract.

If you are not now taking advantage of all your system has to offer through its reports, standard or customized, contact your vendor. It may be well worth it to arrange for some advice or additional training.

PHOTO BY JEFFREY M. HARRIS



# LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.  
Denver, Colorado  
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We are honored to have been selected to join the professionals who participate in bringing you the valuable information presented in this fine publication. This column will appear in *Colorado Medicine* as a service to our clients and prospective clients. Our firm focuses its practice in areas of concern for physicians, hospitals, and health care professionals. We prepare employment contracts for clients and advise clients concerning asset protection in the areas of insurance, risk management, retirement plans, pre- and post-nuptial agreements, and creation of corporate and limited liability entities for professionals. We counsel clients in the areas of taxation and collection of receivables to enhance their profitability. We also professionally represent their injured patients who have meritorious injury claims. Our firm is known for its professionalism and the quality of its legal services. Two principals in the firm are featured in the publication *Best Lawyers in America*.

Future columns will focus on health care issues and pressing issues of the 1990's. Please follow our Legal

Update column during the ensuing months when we discuss and advise you concerning:

- Employment contract protection with your business,
- Buy-sell and non-competition agreements,
- Contracting with hospital and physician organizations with the advent of Integrated Delivery Systems,
- How much insurance you should have and why,
- Risk management programs and audits for your business,
- How to save tax dollars and protect your assets, and
- How to collect receivables profitably and inexpensively.

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For information or to let us know issues and topics you would like to have us cover, please contact:

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# UNCLE SAM IS WATCHING YOU, DOCTOR

## New CMS Booklet Warns of OIG and IRS Collaboration Against Health Care Providers

Attorney **Donald J. O'Connor** of Davis, Graham and Stubbs in Denver has authored a special publication for the CMS, alerting physicians to this newly enhanced danger.

Mr. O'Connor provides vital information on:

- **How the Office of the Inspector General prosecutes "kickbacks"**
- **When IRS denies charitable exemptions for hospitals**
- **How these two agencies have entered an era of unprecedented cooperation**

## You no longer have the option of carrying out "Business As Usual"

Many activities once considered benevolent are now labeled "fraudulent" and "illegal".

### Help Is Available Order this booklet

Mr. O'Connor has written a booklet for the CMS, based on an article he did for the *Colorado Lawyer*. This article gives a lot of detail and specific examples of interpretations of the law and how to avoid violations. Contact the Communications Department at (303) 930-0413 or 1-800-654-5653, extension 413 to obtain copies of the booklet.





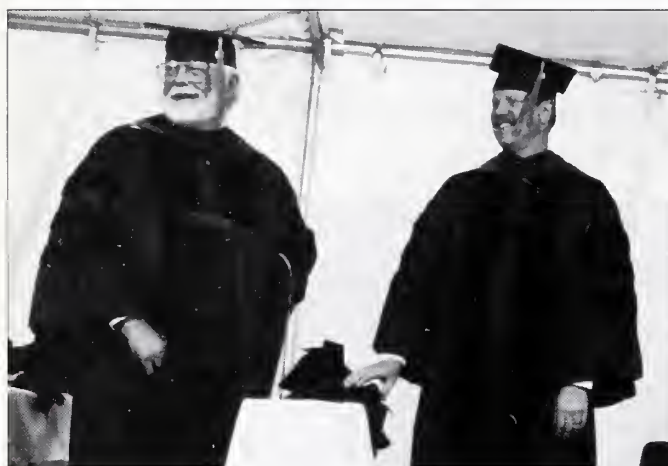
## PRESIDENT'S LETTER

Wm. Carl Bailey, MD  
President, 1993-1994



### Commencement, 1994

***"... those new graduates brought back the thrill of another graduation a long time ago."***



CMS President Dr. Wm. Carl Bailey and Ned Calonge, M.D., President of the School of Medicine Alumni Association, as they hooded the graduates at the University of Colorado

Photo courtesy Univ. of Colorado Health Sciences Center Public Relations Department

One of the privileges which comes with the office of President of the Colorado Medical Society is to become a part of the Admissions Committee of the School of Medicine, University of Colorado. Another is to represent the Society at the graduation exercises of the school. I had that experience this past Memorial Day weekend. Dr. Ned Calonge (President of the Alumni Association) and I were assigned the happy duty of placing the doctoral hood upon the shoul-

ders of each new graduate, or to assist their parents and mentors to do so. It was a proud moment.

As the new graduates passed across the platform, Associate Dean for Student Affairs, Dr. Nancy Nelson, gave a quick (nineteen seconds) biographical vignette of each student. The comments were a

mixture of the serious and the lighthearted, and served to give a fascinating insight into the remarkable character of the Class of '94.

The Dean spoke cogently and with good humor, savoring with the class their exhilaration, looking back with well-deserved pride on their considerable accomplishments, and looking forward

to future successes. As in every graduation, there was the inevitable note of sadness, as farewells were said to alma mater and classmate comrades in arms.

The guest speaker selected by the students was Dr. Joseph J. Jacobs, Director of the newly-formed Office of Alternative Medicine, NIH. Dr. Jacobs gave a warm and personal account of his own pilgrimage, growing up as the child of a full-blooded Mohawk mother in metropolitan New York, spending time on the Indian reservations of Ontario,

and progressing to a career in medicine under the guidance and assistance of many mentors. His sympathetic treatment of cross-cultural issues in the practice of modern medicine was stimulating and provided new perspective.

The thing which most distinguishes a medical school graduation from that of other schools and colleges is the administration of the Physician's Oath. Reciting the oath with those new graduates brought back to me the thrill of another graduation a long time ago.

We live in an age where ceremony is not much observed, and then often grudgingly. Sometimes I think we diminish it too much. Ceremony is, after all, one of the ways that civilized men mark the events they regard as of highest importance. It can be a means to communicate history and renew tradition and values. Reflecting on the significance of these exercises brought to mind a few thoughts I would like to share.

First, I was reminded that Medicine is a uniquely ancient and honorable profession. It is a calling, a vocation to attend the health of one's fellow man and to care for him. Of all present day professions, it may perhaps be said that almost alone it has withstood the ravages of modern culture, although clearly under siege, battered and buffeted. It is becoming harder and harder for doctors to resist the seduction/coercion of the medical-industrial complex and its new class of merchant princes on one hand, and on the other the bureaucratic follies of the politicians, while still maintain-

## PRESIDENT'S LETTER (Continued)

ing human and ultimately personal values intact. As never before, we must try to foster, preserve and to impart to those who follow us the best of medicine's history, culture, and value system.

Secondly, we can be reassured that we need have no fears for the quality or the dedication of our new graduates. They are not only superior students, but marvelous human beings. The Deans and faculty deserve our gratitude for the excellence of their efforts as teachers. But in the end, it is the human qualities of these new physicians which will determine the fiber and vitality of the medical profession in the next years of turmoil. These young people bring to the profession a maturity, a breadth of life-experience and a quality of academic preparation that is truly remarkable. Most of them are saddled with debts, sometimes very large ones, and they are very aware of the tough times ahead for the medical profession. But as I have gotten to know some of them I have found a wonderful spirit of adventure, dedication, and a refreshing desire to help people. I believe the graduating class's choice of the "Physician's Oath for the 21st Century" which I have included here, indicates this spirit.

My last thought concerns mentoring. Medicine in former times was learned as an apprenticeship. One apprenticed himself to a master, and from him learned not only the craft, but much about life and values. Medicine is taught and learned somewhat differently now, but a very large part of it remains "one on one". Under the oath each of us took, we are required to mentor, particularly to the young people. For good or ill, learning and growing never stops. Graduation is a good time to remember that we all acquired our professional character and quality by osmosis and example from respected colleagues.

As we encounter medical students, residents, and physicians newly entering practice, let us take

care not only to impart what we can to their scientific knowledge and skills, but to help them absorb the culture, tradition, and high standards and values that still sets medicine apart, and makes it the rewarding vocation that it is.

*Note:*

*Interested physicians are encouraged to contact CMS or Drs. Nancy Nelson or John E. Repine in the Dean's Office, UCHSC, about the mentoring program for medical students.*

### Editor:

In March, 1993, Dr. William Ezell, then President of the Larimer County Medical Society, wrote in the Society newsletter about the sacrifices that must be made by the members of the healing fraternity in order that care and aid can be given to Medicaid recipients and low income uninsured. Dr. Ezell was reflecting on the health care reform movement which specifically refused input from organized medicine. As he said, "War is too important to be left to the Generals", Medical Reform is too politically important to be left to the care-givers. And so, he calls on his professional fellows to give more. Ezell said "With few exceptions, physicians adhere to the ancient precepts of service and sacrifice; ethics and professionalism. We are familiar with the Physician's Oath penned by Hippocrates in 400 B.C." Ezell went on to say, "There is also wisdom in another of Hippocrates' writings, *Precepts, Chapter One*:

*'Sometimes give your services for nothing, calling to mind a previous benefaction or present satisfaction. And if there be an opportunity of serving one who is a stranger in financial straits, give full assistance to all such. For where there is love of man, there is also love of the art.'*

## Physician's Oath for the 21st Century\*

*As I don the hood of physician these things I promise:*

*I will educate my fellow humans so they may avoid illness, and whenever possible, I will prevent disease in the recognition that prevention is far better than cure.*

*I will counsel my patients to the best of my ability, and apprise them of all medical and social options, my own personal biases aside.*

*I will avoid arrogance for it is dangerous, and I will avoid the temptations to believe that my opinion is always the right one.*

*I will not treat a patient when I am not qualified to do so. I will be quick to call upon my colleagues for advice, and I will be quick to render aid when asked.*

*I will use medical resources wisely, for they have limit.*

*I will remember that death is not my enemy but is the natural end of life.*

*I will promote ethical conduct within my profession.*

*I will help teach my colleagues and future generations of physicians.*

*I will remember that in addition to being a physician, I am also a citizen of my country and my world. I will speak out when silence is wrong. I will recognize that disease is not limited to the individual but afflicts all of humanity. I will fight ignorance and injustice as well as disease.*

*Though I will be dedicated to medicine, I will remember my family and those close to me. I will celebrate this gift of life, as I help others.*

*...anon 5/94*

*\* from the*

*"Hooding and Oath Ceremony  
in Honor of the Class of 1994"*





## HEALTH AFFAIRS COUNCIL

### Rural Health a major topic of discussion for CMS Task Force

*"...a cadre of devoted physicians serving some of the most remote, rural areas in the U.S."*

As we move swiftly toward the 1994 CMS Annual Meeting, the Rural Health Committee of the Health Affairs Council is wrapping up a year-long project and formulating recommendations to be made to the Council. The Council will then prepare a resolution to recommend to the House of Delegates to move CMS in a direction to assist physicians practicing in rural areas.

Jack Berry, a Family Physician from Wray, Colorado, has taken this Committee to four different locations in the state since last September. Included were meetings with local physicians in Rocky Ford, Craig, Fort Morgan and Cortez.

When adjourning the last meeting in Cortez, Dr. Berry said the problems of the

rural physician seem to be much the same anywhere in the state, i.e., lack of incentive for physicians to commence practice in rural areas or join existing practices.

Berry says that there are four areas in which his committee thinks CMS could be of help: 1) help create incentives to encourage more

physicians to go into rural practice, i.e., legislation, scholarship programs and loan repayment plans; 2) help local communities establish a rural training track residency program and help physicians get a resident into rural offices; 3) encourage a change in attitude of the University of Colorado School of Medicine toward primary care, especially rural practices, and; 4) work toward reducing cultural and professional isolation, i.e., integration and expansion of resident training programs and creating a statewide, CMS-operated physician's network to relieve rural doctors in matters of contract review and negotiation.

Dr. Berry said that CMS can also help rural physicians make more skillful use of midlevel providers, necessary to most rural areas, but not the most efficiently used at the present time. Berry said "We need to use the mid-level providers more skillfully, but the medical doctor must continue to be the basis of health care delivery in rural Colorado. I believe Colorado Medical Society can help us accomplish this.

Dr. David Herr of Grand Junction said the last point presents a problem in urban areas because the doctor is more threatened by mid-level providers. Dr. Leonard Cain of Cortez said this is not just the case in urban Colorado; it is true with the rural physicians as well, and this is where utilization of the mid-level



Dr. & Mrs Jack (Maribeth) Berry with Dr. David Herr at the Rural Health Committee of the Health Affairs Council meeting in Cortez, Colorado in June. Dr. Berry is the Committee Chairman. Dr. Herr is a Pediatrician from Grand Junction.



provider is not efficient. Dr. Dianna Fury, also a Cortez physician, said that there were presently one and a half physician's assistants in practice in the four-corners area and that they are very important because the physicians in Cortez alone cover an area of 4,500 square miles and a patient base extending into all four states and two indian reservations.

Dr. Kent Aikin of Mancos said there were new problems being presented in this remote rural area by the large increase in population, particularly older people. Aikin said that suddenly there is a need for a specialist in geriatric medicine, and there just aren't the physicians to provide such specialized care. Dr. Aikin pointed out that Mancos, with a population of around 1,300 (842 in 1990 census) has just added an 80-bed extended care nursing facility, and he is the home's medical director, but is the only physician to handle hospital admissions from Mancos at the Cortez hospital (20 miles distant), so he

makes that trip daily. In addition, Aikin says, running a practice in such an area where you have no one to cover for you is extremely taxing on personal health and family life, while continuing medical education and any socializing practically go out the window. This feeling was echoed by several of the physicians attending the Cortez meeting, and all felt it was extremely taxing to attempt to do a solo practice in a rural setting.

Dr. Berry said one of the greatest tools to relieve this situation was the residency program. And, he said, these are the most likely candidates to return to a rural practice once their schooling and internship is done.

### ***How CMS Can help:***

1. *Help create incentives for rural practice*
2. *Rural training and residency*
3. *Change medical school attitudes toward rural practice*
4. *Reduce cultural and professional isolation*



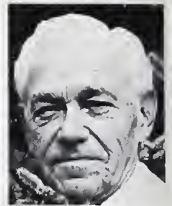
*Physicians at the Rural Health Committee meeting in Cortez were (l to r) Kent Aikin, FP, Mancos; David Herr, Ped., Grand Jct.; Dianna Fury, FP, Cortez*





## THE LOBBY

by Frederick A. Lewis, Jr., M.D.,  
Chair, Council on Legislation  
Colorado Medical Society



### **Quote of the Month:**

*The best way to pay for Clinton's health care plan is to have everyone do a physical on the person to their left "*

*- Bill Meyer  
Time Magazine*

One of my New Year's resolutions, long since discarded, was to stop writing articles on health care reform. However, having attended two national and one state meeting over the past two weeks, the subject seems irresistible.

Despite the headlines, less than 20 percent of the action is taking place in Washington and at least 80 percent is currently taking place in the private sector. Private sector forces are continuing to shape and reshape the market and anyone who tells you that they can predict the final outcome is either fabricating, trying to persuade you to give up, or both.

The health care industry is continuing to evolve and the current situation appears to be a transitional phase. At this point, organized medicine's best bet seems to be to try to prevent the legislature (either federal or state) from attempting to solidify a process which is still very fluid. At this point, almost any effort to legislate the private sector is likely to add confusion to an already complicated situation.

There are still too many physicians who do not understand the difference between managed care, health care reform, and managed competition. Managed care refers to a set of techniques used by or on behalf of purchasers of health care to control the costs of health care. Health care reform refers to governmental legislative proposals to restructure the health care delivery system. Managed Competition" is just one of these legislative proposals. Essentially, we have two choices; government medicine or

free market medicine- "Managed competition" is simply another euphemism for government medicine since competition would be "managed" (controlled, run) by the government.

When you add in the costs of administration and share holder profits, there are no studies which suggest that "managed care" saves any money in terms of overall health care costs. In addition, there are two systems of private sector health care delivery which are completely unmanaged. One is fee-for-service medicine as it existed 35 years ago, before the advent of Medicare and Medicaid. The other is a totally capitated delivery system which can also function in an equally unmanaged fashion. The primary difference between the two systems is that the risks and incentives are quite different. In fee-for-service medicine, the physician takes no financial risk and is financially rewarded in direct proportion to the number of services he performs. In a fully capitated system, the physician (or capitating entity) assumes all of the financial risk and is financially rewarded for providing as few services as possible. It is quite possible to provide quality medical care (without medical management) under either system. Physicians generally argue that patients are more likely to receive quality medical care under a fee-for-service system, whereas the people who ultimately pay for most of the cost of medical care (business and government) argue that it costs less under a capitation system. Both parties are probably correct; however, if capitation becomes the

## THE LOBBY (Continued)

reimbursement mechanism for most of the country, the price differential between programs will probably become small. At that point, competition will again be based on quality. This would be similar to what occurred in the automobile field (U. S. v. foreign manufacturers) several years ago.

The only other possibility is a fee-for-service delivery system with fee schedules, budget caps, strict rationing by society, and abolition of heroic and futile medicine. It seems highly unlikely that our political system will allow this in the foreseeable future.

It does seem highly likely that the group, entity, organization, corporation, etc., that negotiates and controls the capitation contract is in a position to make a great deal of money. The current entities competing for this plum are insurance companies, large for-profit health care corporations, the government, and physician/hospital partnerships (which are taking many different forms). Unfortunately, at the present time, physicians are the least well organized of all of these groups and, therefore, are at the greatest competitive disadvantage. One can only hope that this will change.

One of the things which has become apparent in my fourteen year association with COPIC is that in our capitalistic society, people are reimbursed for taking risks. Examples abound. The job of insurance companies is risk assumption and most do quite well. If the risk becomes unacceptable, they can simply leave the market (Hartford in 1984). In the financial markets, greater risk is almost always associated with greater return. Venture capitalists expect (and receive) a greater return than individuals who invest in government bonds. People (or corporations) who manage risk successfully, usually make money. Health care reform in the private market can be understood as a paradigm shift from financial reward

based on providing a service to financial reward based on the assumption or risk.

There are several different financial risks in the capitation reimbursement system. You can lose money if the capitation premium is too low and too many people enroll or, conversely, if the quality of care is low and too few people select your program.

The legal system is in the process of transferring some of the liability (risk) from physicians to the current contracting entity. (HMOs, PPO's.) On the other hand, "hold harmless" clauses are an attempt on the part of managed care entities to prevent this transfer of risk. Practice parameters are an attempt at risk management. Outcome studies are an effort to measure end compare risks.

Ironically, if one looks at all of the players in the health care delivery system, only physicians have the knowledge necessary to successfully manage the risk inherent in health care delivery. Certainly, insurance executives, CEOs, or hospital administrators do not possess the knowledge necessary to structure the system so that it provides the highest quality care at the most economical price.

Physicians have a choice. They can either learn to manage financial risk for their own benefit, or function as risk managers for insurance and health care corporations.

Individuals go into medicine for many diverse reasons. However, probably high on the list of most physicians are 1) A desire to practice quality medicine and render a necessary service; 2) Personal autonomy, and; 3) the prospect of financial security. All of these goals can be realized by physicians who choose to organize themselves as the risk managers of a capitated health care delivery system.

In any event, have faith - it would appear that managed care and gatekeepers may well be simply a transitional phase between fee-for-service medicine and reimbursement by capitation.



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# hat can one man do?

by Paul G. Becker, M.D.  
Denver, Colorado

*"... there is no limit to  
what one man can do."*

What can one man do? At a time when powerful politicians, whole segments of the labor movement, and what appears to be a majority of the public subscribe to the short-range view and clamor for a revolutionary change in our system of medical care, the individual physician, the individual member of the county medical society and of the AMA, the individual American seems insignificant indeed.

Living in such a complex and impersonal world as we are today, we are faced with the question, "What can one man do?" There is a feeling of impotence when the individual faces the titanic forces present in our modern civilization, and we have the feeling we are foundering in a flood of uncontrollable powers. This feeling becomes more acute in an election year, when the individual vote seems so pitifully insignificant.

Yet human experience again and again negates our emphasis on the huge, the vast, the colossal.

**ROBERT SPEER**, in an issue of *The Christian Advocate* some years ago, related a story which traces the influence of one vote cast in an election in Switzerland County, Indiana, in 1844. David Kelso was running against David Haney for election to the State Senate. Previously, Kelso had served as lawyer in defending a young man accused in a fatal shooting affair. Kelso's client was acquitted, and the gratitude he won on that occasion bore fruit on election day, when his client, although ill, insisted upon going to the polls to cast his vote for Kelso. It was a 10 mile trip to the polls and

was made against the advice of a physician. The long, cold ride was more than the sick man could tolerate, and resulted in his death, but David Kelso won by one vote. It then became the responsibility of the Indiana State Senate to fill a vacancy in the U. S. Senate. The Whigs and the Democrats were evenly divided, but the Democrats had a narrow majority of two. However, Kelso, who was a member of that majority party, refused to accept his party's nominee, Oliver Smith. He independently selected his own candidate, Edward Hannigan, and was successful in gaining the support of another Democrat. As a result, the election was deadlocked with a vote of 74 to 2. After repeated ballots, Kelso finally issued an ultimatum to the other members of his party, threatening to support the Whig candidate unless the Democrats dropped Oliver Smith in favor of Hannigan. Kelso won, and Hannigan was elected.

The next year a bitter struggle broke out in Washington over the admission of Texas to the Union. Oliver Smith had promised that, if elected, he would vote against this measure, but Hannigan, elected because of Kelso's efforts, voted for Texas' admission and that one vote proved to be the narrow margin by which approval was given to statehood. This action later resulted in war between the U. S. and Mexico and in the further acquisition of territory for the United States. Surely that one man's vote cast back there in Switzerland County, Indiana, proved to be of considerable importance.

**Editor's note:** Paul G. Becker, MD, of Denver first wrote this essay for the Denver Medical Bulletin in 1964. In 1972 it was again published, this time by the American Medical News. We are pleased to publish it a third time because the wisdom, the thoughts, the fears and the needs are just the same today as when first written.

**BARNEY FORD**, a runaway Negro slave, came to Colorado and opened a barber shop in Denver. He was obsessed with the abolition of slavery and convinced many of his customers, who in turn encouraged him to carry his battle to the nation's capitol when a bill was before Congress to give Colorado statehood but deny Negroes the vote. Ford and his lobby succeeded in influencing President Andrew Johnson to veto the bill. Had Ford not been successful, Colorado would have sent two anti-Johnson senators to Washington - enough to impeach President Johnson - but Johnson survived by one vote. Later Ford proposed Colorado statehood with suffrage for Negroes, and this became reality in 1876. In that election year Democrat Sam Tilden and Republican Rutherford B. Hayes were tied and the Electoral Commission had to decide the election. Colorado's electoral votes gave the presidency to Rutherford B. Hayes. What can one man do? A runaway slave named Barney Ford did plenty!

Innumerable instances come to mind reminding us of the far-reaching influence of individuals, both great and small. Doctor Laennec, strolling past a school yard, saw two boys, scratching signals along the plank of a teeter-totter, and the stethoscope was born. Isaac Watt saw steam lift the cover from a pot simmering on the hearth, and an idea germinated which found substance in machines that were destined to rebuild continents and civilizations.

**WE THEREFORE** can and must conclude that there is no limit to

what one man can do. It is not always a matter of genius, but of an individual's devotion to great causes. Lincoln was not regarded as exceptional by his early associates, but on the contrary, many thought him crude and ordinary. Few have the potential of a Lincoln. It is unlikely you or I are destined to fill the role of world leader. So what can I do? What can you do? What can one man do?

We can let our elected representatives know where we stand on issues that confront us. We tell our colleagues how we feel but seldom take a stand in public. Let's convince others, inside and outside our profession, and with them convince those in Washington. Think of the tremendous effect on Congress if each physician would keep the faith, would grasp the torch, and convince a few hundred citizens to register their individual approval or disapproval of legislative proposals.

**EACH OF US CAN** support those leaders in our society, city, state, and nation who need assistance in the struggle we believe in. We can serve on committees of our society that need our talents and on our hospital committees struggling to upgrade the quality of care and struggling to reduce the cost of care in our institutions. We can arm ourselves with facts and write and speak. We can inform the needy of the existing programs available for their care. We can see to it that no one lacks adequate care. We can work toward the improvement of existing programs and encourage people to provide for their own care. We can provide our patients with the best

care we are capable of at a fair cost to them and at the same time dispense free concern, free kindness, and free friendliness. We can vote and encourage others to do likewise. Who knows but that someday a patient's gratitude to some unknown doctor, like the gratitude of the client in Switzerland County, Indiana, nearly 130 years ago, may influence a vote that may affect the future of medicine and the destiny of Americans.

Is your medical society, your AMA, your America doing its job properly? They are if you do your job, if I do my job, because we are the society, we are the AMA, we are America. What can one man do? Plenty! So let us get moving.





# Putting the RAM into the Cottage

(or how HCFA has changed direction radically to pursue Quality Improvement)

by Fredrick R. Abrams, M.D.

***"How doctors treat their next patient can be predicated on more than how they treated their last patient. . ."***

Although there still may be a few letters trickling out of the Colorado Foundation for Medical Care (CFMC) left over from the previous phase of chart review, that will soon cease entirely.

There is no doubt that some dubious practices were revealed during this era of what may have been construed as micromanagement, and improvements did follow as a consequence of this type of review. But overall, the longer this "bad apple" theory was followed, the less productive it appeared to be. Some doctors felt it was downright nitpicking, and some felt it was Monday morning quarterbacking. To the Healthcare Financing Administration (HCFA), in either event, it appeared that maximum benefit had been reached, and a new approach that is much more collaborative has been introduced. The emphasis is on overall improvement of care rather than trying to single out individual instances of bad care. And the entire medical community is being asked to help.

There are at least two new approaches and they are both products of the information age. For centuries, medicine has been confined to a one-on-one relationship. That remains critically important. But for several decades, new methods of communicating large amounts of data have made it possible to compare medical processes and their outcomes over a much broader base. How doctors treat their next patient can be predicated on more than how they treated their last patient; it can be based on hundreds of treatments

and outcomes, and best practices can be discerned. As a consequence, what has been a cottage industry that depended on personal experience, anecdotal case reports, and placebo effect can (without discarding those still-valuable elements) be augmented by computerized data bases.

HCFA has established 1) the healthcare quality improvement process, (HCQIP, often pronounced hiccup) and 2) the medical quality indicator system (MQIS). Both focus on the analysis of practice patterns without focusing on individual physicians. HCQIP improvement projects start with an idea about diagnosis or treatment. An area is chosen where it is felt patients are not getting the benefit of the best medical practice. For example, there may be an unwarranted delay in diagnosis, or an overuse of a diagnostic or surgical intervention. Other examples might be failure to use an antibiotic, or to monitor for sensitivity or toxicity.

Once the idea is suggested, it is turned into a hypotheses such as "patients with myocardial infarction are not being treated with ASA or thrombolytics soon enough". Then from the database, CFMC tests the hypothesis. The information is fed back to the hospitals where their results can be compared confidentially with other similar institutions both within and outside of Colorado. Many of our hospitals and doctors will demonstrate excellent benchmark results for others to emulate. Ideas for improvement projects come from a variety of sources including HCFA, CFMC, hospital quality committees and individual physicians.

The MQIS projects begin with HCFA which assigns a disease entity to a PRO such as CFMC. CFMC does a literature search on a phase of that disease to find quality indicators (QIs). A QI is a diagnostic or therapeutic intervention upon which there is virtually universal agreement that experience backed by the strongest scientific evidence confirm, as the best practice (resulting in the best outcomes). A panel of advisors from doctors and other professionals is convened to determine the QIs. The panel does not create indicators. The task is not to forge a consensus but rather to select indicators that are already supported by the strongest possible evidence. It is not meant to be "cutting edge" but solid indication of best practice processes based on outcomes.

These QIs are then used to evaluate hospital records. Individual doctors are not identified. Instead, the data are fed back to the hospitals allowing them to compare themselves (anonymously) with other institutions. At this point, HCQIP and MQIS may converge. Hospitals may use the data to establish CME programs, and CFMC may be called upon to help.

Doctors may become involved in a number of ways. They may see an area in their hospital where they feel care may be improved. CFMC may run data searches for them. If they have a role on a hospital quality committee, they may be looking for a project or help with one to satisfy JCAHO requirements. CFMC can help. And very important, when CFMC approaches hospitals for volunteers for the panels, they can offer some time — usually only four or five hours spread over several months, often by conference call.

CFMC looks forward to collaboration with doctors and hospitals all over the state so they can demonstrate that these new processes promise quality improvement from a collegial rather than a supervisory micromanagement approach. If you wish to volunteer, suggest a project, have questions or need help with data, please call Dr. Abrams or Jeanette Field at (303) 695-3300.

## A. M. Best upgrades rating of Copic

A. M. Best, the principal rating agency for U. S. insurance companies, has rated COPIC Insurance Company "A - Excellent" based on operating results through year end 1993. Both the Board of Directors and management are pleased with this rating and its reflection of the strength and operating performance of the company.

Having first qualified for a Best's rating in 1992, conditioned upon the results of seven years of operation in the long-tail professional liability line of business, COPIC was granted an initial rating of "B++ Very Good" in July of 1993. For a first rating, we were comfortable with that assignment, but are even prouder of this advancement to the A- level.

To quote from the A. M. Best publication **1993 Best's Insurance**

### **Reports - Property and Casualty:**

"The objective of Best's rating system is to evaluate the factors affecting the overall performance of an insurance company in order to provide our opinion of the company's financial strength, operating performance and ability to meet its obligations to policyholders. The procedure includes quantitative and qualitative evaluations of the company's financial condition and operating performance."

Receipt of this rating from Best's provides additional evidence of the soundness and quality of COPIC, Colorado's only domestic professional liability carrier, operating from offices in the state solely for the benefit of over 4,000 insured professionals and their staffs, employees and business entities.

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## CMS MEMBER SERVICES

by **Bill Pierson, Director**  
Communications & Member Services

### CMS Member Service Programs Updated

**NOW: NO ANNUAL FEE**  
for CMS members



The Colorado Medical Society is pleased to announce three important enhancements to the CMS-MBNA America® MasterCard® and Visa® credit card program, one of the major association member benefit programs.

#### **1st: NO ANNUAL FEE**

Effective immediately, both new and existing cardmembers will no longer have to pay an annual service fee for the Colorado Medical Society MasterCard® or Visa®. It is now a NO FEE credit card.

This valuable benefit translates as an immediate and recurring savings for Standard and Gold Colorado Medical Society cardmembers -- with no reduction in the exceptional benefits cardmembers currently enjoy with the Colorado Medical Society MasterCard® or Visa®. Colorado Medical Society has worked a long time with MBNA America and their representatives to establish a "no annual fee" credit card for its members, and it is because of past successes of the card (the number of CMS members who have been cardmembers) that this latest advantage has come about. We are pleased and enthusiastic about this development.

#### **2nd: Special Limited-Time [8.9%/9.9%] APR**

Effective immediately, **new** Colorado Medical Society cardmembers will be offered a special limited-time [8.9%/9.9%] APR (Annual Percentage Rate) on cash advances and balance transfers. The new account welcome package will include two specially designed

checks that can be used to close higher interest credit cards and other loans.

#### **3rd: Employment-Related HIV Supplemental Income Protection - Up to \$300,000.00**

This unique benefit is now available to new and existing **active** Colorado Medical Society Gold cardmembers who maintain their accounts in good standing. It's easy to take advantage of this coverage. There are no applications to complete, no payments to make, and no health screening is required. For new Gold cardmembers, complete details regarding the Employment-Related HIV Supplemental Income Protection will accompany the Gold Card new account fulfillment package. For existing Gold cardmembers, complete details will accompany the monthly billing statement.

The Colorado Medical Society credit card, administered by MBNA America, was created to meet the lifestyle demands of busy physicians. It is a powerful credit card, offering physicians maximum benefits and exceptional value.

The Colorado Medical Society MasterCard® or Visa® are the only credit cards to be endorsed by the Colorado Medical Society. Colorado Medical Society has offered this member service credit card program since 1981, consistently one of the most successful programs of its type in the U. S.



### Overnight Express/Package services through special physician discount program for CMS members

Colorado Medical Society has entered into an agreement with **Airborne Express®** which will allow CMS members and their offices up to a 40% discount on some overnight express shipments.

In any case, any physician subscribing to this program will receive a substantial discount on the cost of expressing overnight letters. As an example, an overnight letter sent by one of the other major air express firms could cost as much as \$15.50, while on Airborne Express, through the CMS program, you can send that 8oz letter for \$9.25, with no extra pickup fees from most locations.

You can get this discount because you are a member of Colorado Medical Society.

- No cost to you.
- No monthly fees or minimum usage.
- No charge for standard supplies.

If you haven't already received it, watch the mail because there will be mailings from AirBorne Express with an application. Or, if you call 1-800-642-4292 and tell the agent you are a member of the Colorado Medical Society and want to join this program, you should have everything you need in three business days.



### Exciting vistas and superb travel experiences await CMS/ INTRAV travelers in '95

1995 is literally upon us . . . at least in the travel business. It is vital that travel companies or planners plan well in advance, securing facilities in various locations - throughout the world!

It is also vital that the organization be well organized when putting together tours, so that all interfacing with the host country is done in advance and there isn't even a ripple of unhappiness or discontent when the travelers actually reach the foreign country.

But who's to plan where the tours will go? I don't know who it is with **INTRAV**, but he or she is apparently an expert. Look at this agenda for 1995:

- Panama Canal Cruise
- Australia/New Zealand
- Wings Over Kilimanjaro
- Danube Canal Cruise
- Alaska
- Greek Isles Passage
- China
- Hilltowns of Italy
- Panama Canal Cruise (fall)

One of the secrets of this planning is the great success and popularity of the cruises in past years. Couple that with the fabulous service and attention the traveler gets from INTRAV's staff worldwide, and you have the reason that people return to INTRAV tours year after year.

What do you get as a CMS member for going INTRAV? You'll get special attention and service from the first moment, for one thing. Call us and find out how you're treated. Then, when you discover that you will be traveling with other physicians and their family members, you suddenly have a comfort level about this tour that you don't get from any other tour. INTRAV has been specializing in arranging tours for medical societies and professional medical organizations for a lot of years. CMS has been working with CMS for the majority of the past 26 years.

Colorado Medical Society and INTRAV do not market or push CME

on its trips; if you specifically want CME for credit on these cruises or tours, ask for it and you can deal directly with INTRAV. CMS will be happy to handle all the preliminaries, such as questions about specific tours, reserving you a space, etc., but when it comes to talking about trip details, we'll quickly put you in touch with an INTRAV representative who will be delighted to help you. Honestly, they couldn't be nicer. And it won't even cost you a telephone toll.

Watch for the mailings; they come from INTRAV . . . not from CMS. And remember, CMS sponsors INTRAV as a member service because of all the years of wide acceptance and satisfaction by our members. There's nothing that comes out of your dues dollar. It all comes from INTRAV.

### Members Long Distance Telephone Advantage is a quiet program, but is a winner after its first 18 months at CMS

This program doesn't need much talk . . . it is saving money for a lot of CMS members . . . up to 25% on all long-distance calling. No charge to you and you'll just dial 1+ area code + number as you do now, with operator and directory assistance 24 hours a day, seven days a week.

Call CMS and find out how you can join. And with a very recent

upgrade, if you become a member of the Advantage program you can receive employment-related HIV insurance at no added cost. You'll be hearing much more about

this soon, but call us now and we can give you a head start. For any member service information, call me, Bill Pierson, at (303) 779-5455.





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by Robert D. McCartney, MD  
and Joel M. Karlin, MD  
AMA Alternate Delegates

# CHOICE: The Cornerstone for Health System Reform

## and the physician's weapon to level the playing field

The health care delivery system is changing in the light of reform. Whether a bill passes Congress this year or not, market forces are changing the way we practice medicine. No longer can a young physician open an office and simply wait to see patients. Currently, choices for health care insurance are made by employers who pay for the coverage. Because insurance is part of business overhead, the decision for insurance is based upon economic considerations, not the more important issues of an established doctor-patient relationship, quality, choice of specialty physician, or hospital preference.

So what is the answer? A single-payer, government-run "Canadian or English" system where every physician would have access to patients, but be limited by bureaucratic budget caps and rationing? Or an "any willing provider" law for Colorado which would allow any physician to join any provider group, limiting the ability of physicians to determine with whom they want to practice and in what type of delivery system? We think not. We believe the ultimate system to be a free market, consumer-driven system based on quality, accessibility, and reasonable costs. In such a system, the patient would select and own

their health insurance plan. This would allow the patient to choose a physician, a hospital, a delivery system. This would create true competition at all levels in the system, and allow the cream to rise to the top. We have all competed throughout our lives dating back to grade school. Competition on a level playing field should be our goal.

How can we get there? The path will most likely be through several intermediary steps. At the recent AMA House of Delegates meeting in Chicago, your Colorado AMA Delegation brought forth the concept of separation of who pays for the health insurance plan from who selects the health insurance plan. An example of separation choice of health plan and payment for health plan is a "health purchasing cooperative" or an alliance. In such a system, an employer contributes a fixed dollar amount to the cooperative for the purchase of health insurance for each employee, and the employee makes the decision which plan is best suited for his or her personal needs. Any difference in cost for the plan selected by the employee over that which is contributed by the employer would be borne by the employee. We tried unsuccessfully this year to amend the purchasing cooperative bill passed



Robert D. McCartney, MD



Joel M. Karlin, MD





*Continued...*

by the Colorado Legislature to allow employee choice. We will attempt to change the sentiments of the Colorado Legislature next year. We hope the U.S. Congress will understand the distinction of choice of plan and payment for plan. But until that happens, AMA has developed, through input from physicians nationwide, the first step. It is the "Patient Protection Act", HR-4527, introduced into the US Congress by Colorado Congressman Wayne Allard and Minnesota Senator Paul Wellstone. It has bipartisan support in both houses of Congress. The key components are:

### **Patient Choice**

The proposed bill protects the patient's choice of physician and health plan. It requires sponsors of health benefit plans to offer at least 3 options: an HMO or PPO plan; a traditional fee-for-service plan; and a benefit payment schedule. For those managed care plans which limit access to providers, it mandates a "point of service" option to allow enrollees access to providers out-of-plan.

### **Patient Protection**

Managed care plans would be required to provide information to prospective patients regarding their health care delivery system which include: coverage provisions and exclusions; prior authorization and other review requirements; financial arrangements that would limit the services offered, restrict referral options, and establish incentives not to deliver certain care; plan limita-

tions and the impact of limitations upon enrollee; loss ratios; and enrollee satisfaction statistics. Plans would have to provide information on physician:patient ratios for primary and specialty care, and demonstrate financial viability.

### **Physician and Provider Fairness**

Managed care plans would be required to establish physician credentialing criteria for plan inclusion. Such credentialing would be based on quality standards. Plans could use physician-developed criteria to determine number, geographic distribution, and physician specialty requirements. Physicians would have access to physician profiling data. Physicians would be able to give input into policy development of the plan. "Termination without cause" would be prohibited, and due process appeal protection would be available for "termination for cause". Reasons would have to be provided to physicians for rejection of application for initial participation or renewal of a contract.

### **Safeguards in Utilization Review**

Federal certification would be required of qualified utilization review standards. Information would be released to both patients and physicians regarding techniques used to review medical care. Such criteria would have to be based on sound scientific principles developed with physician input. Denials for payment

for services rendered would have to be reviewed by a physician of the same specialty. Quick approval for authorization for service would be required.

We believe this bill would do a lot to alleviate problems created for patients and physicians by certain managed care organizations. It is not an "any willing provider" bill. It establishes fair rules by which physicians can compete while making the patient an informed consumer of health care. It is the first, but a major step, leading to a system built around patient choice. We believe our AMA has put forth a plan which can and should be implemented irrespective of any other health system reform legislation. We hope you agree. If you do, please contact your US Congressional Representatives and Senators and ask them to support HR-4527, "The Patient Protection Act".

Our slogan as we go forward unified in the house of medicine should be:

**My doctor ...  
my choice.**



May 12, 1994

Dear Editor,

Copic and the Colorado State Board of Medical Examiners are now forbidding doctors to hug or kiss patients at any time and under any situation. What is this world coming to when members of a caring profession cannot express the normal human emotion of love to their patients or receive it from them?

I have said for a long time I would quit the practice of medicine when I was required to put on a rubber glove to shake the hand of a patient. That time is fast approaching.

Joseph S. Pollard, MD  
Colorado Springs, Colorado

May 9, 1994

To the Editor

Subject: Colorado State Science and Engineering Fair

We as doctors give a lot of lip service to our young people and to scientific education but when it comes to giving our time we say we are too busy.

The Colorado State Science and Engineering Fair for junior high and high school students involves thousands of young people and are they *bright!* Hundreds of teachers from the small local fairs to the International Fair give their time and patience to these young people. The awards luncheon to which students, parents and reporters are invited is always sold out — 500 usually.

The Colorado Medical Society has for many years supported the Fair. There are several students, maybe many, who have become doctors or gone into paramedical fields as a result of participation.

At the present, the Fair is being held in Fort Collins, using the facilities of CSU. The University has been of great help in providing facilities, but the Fair is fast becoming a Northern Colorado Regional Fair because of distances necessary to travel from Southern and Western Colorado. Even so, a minimal number of dedicated teachers make the trip.

Becoming involved in the Fair in one of many ways offers a terrific opportunity for some doctors, not only as judges but as directors of the Fair. The medical society has 4 openings on the board of directors, usually meeting in September. Will some doctors, men or women, please step forward to help?!

Maybe the Fair can be moved to Denver. It has been held in Fort Collins too long — is becoming inbred. The Fair actually met without a director last year. They need publicity, people, and money. Is this country run on anything but sports?

Calvin Fisher, MD  
Colorado Springs

*Editor's Note: There are those physicians in Colorado who share Dr. Fisher's concern for the future of science education and the Science Fair. Drs. Gordon Tagge and Bruce Belleville, for instance, recently served as volunteer judges for the Science Fair on behalf of the Colorado Medical Society. (See sidebar)*

## 1994 Colorado State Science Fair

Gordon K. Tagge, MD

Dr. Bruce R. Belleville and I had the privilege recently of serving as volunteer judges at the Colorado Science and Engineering Fair at Colorado State University in Fort Collins.

The exhibits were divided into two divisions, senior and junior. Subject matter included Botany, Earth and Environmental Sciences, Engineering, Health and Behavior Science, Mathematics and Computer Science, Physical Sciences and Zoology.

Each year, the Colorado Medical Society sponsors an award in each of the two divisions for excellence in medical-related research. We selected as the Senior Division winner, Nathan Kelly, grade 12 at Merino-Brush High School for his project, *Isolation and Subcloning of a 14.8 Kilobase DNA Fragment from the Ser 2 Gene Cluster*. In the Junior Division, we selected *Hand-Eye Coordination* by Dale A. Evers, Jr., grade 8, Colorado Springs-Chal-lenger Middle School.

The judges enjoyed the opportunity to interact with the students. We were impressed with the creativity of the students and their competitive spirit. We look forward to involvement next year and appreciate the Colorado Medical Society's involvement in this extremely worthwhile endeavor.

Dr. Tagge has also volunteered to serve on the Science Fair Board.



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## Colorado Physicians Influence National Politics



CMS member **Janak G. Joshi, MD** and his wife **Anjana Joshi** were among those from Colorado who attended the National Political Education Conference in Washington, DC, sponsored by AMPAC, the American Political Action Committee.

At the conference, physicians learned how to influence the political process at all levels, including meeting Senator Bob Dole, (R-KS), Senate minority leader and a major player in the health insurance reform debate.

## Physician's Recognition Awards

John R. Alessi  
Bruce R. Baird  
Phillip J. Bogner  
Mark M. Boucek  
Richard L. Brundige  
Norman F. Clothier  
George F. Cresswell  
James W. Guyer  
Joy L. Hawkins  
John P. Haws  
Daniel R. Henley  
John L. Hudson  
Larry W. Kipe  
Cynthia J. Owens  
Robert S. Pace  
Joseph S. Pollard  
Victor S. Sierpina  
Christopher J. Smith  
Duane R. Spaulding  
Wallace B. Sullivan

# "Here's Lookin' at YOU, Doctor"



Sandra L. Maloney  
Executive Director  
Colorado Medical Society

**Humphrey Bogart**, in the 1942 classic movie, *Casablanca* spoke those immortal words to Ingrid Bergman, "Here's lookin' at you, kid," and they have passed into immortality. They are used today by people who have never even seen the movie. We are using them for this meeting to ask you about everyone who looks over your shoulder as you practice medicine. Our educational program will ask "**Who's** looking at you?" You'll find it very enlightening.

Did you know that almost everything the CMS staff, Councils, Committees and Task Forces do is determined by resolutions presented at the meetings of the House of Delegates? Not only that, but each member has an equal opportunity to present resolutions for consideration, to testify before a Reference Committee (or even serve on one) and to have a dramatic impact on the direction CMS will take on important issues in the coming year. The Colorado Medical Society really *is* a member driven organization.

We have lots of educational and fun activities scheduled for you this year, in addition to the business meetings that set CMS policy and drive all our activities for the year.

Look over the enclosed information, select those activities and meetings in which you would like to participate and fill in your registration form. You then may mail it to us (at PO Box 17550, Denver, CO 80217-0550), phone it to us (at 303/779-5455) or even FAX it to us (at 303/771-8657).

Get your registration in quickly. There are limited spaces available for some programs. Notice also that you will need tickets for all meal functions. We must remain fiscally responsible by getting an accurate count of those who will attend these functions.

I look forward to seeing you in Beaver Creek!

Sandra L. Maloney



# COLORADO MEDICAL SOCIETY

## Tentative 1994 Annual Meeting Schedule

Hyatt Beaver Creek  
September 8-11, 1994

### THURSDAY, SEPT. 8

10:00 am -	18-hole Golf Tournament
-	Beaver Creek Golf Club
11:00 pm - 1:00 pm	Finance Committee
1:00 pm - 5:00 pm	Board of Directors
3:00 pm - 6:00 pm	CMS Office open
4:30 am - 8:00 pm	Registration open
6:00 pm - 7:00 pm	"Here's Looking at You"
	Reception
7:00 pm - 8:30 pm	"Here's Looking at You" Dinner

**NOTE:** Dress for Annual Meeting

**Thursday evening reception/dinner:** *Casablanca* or casual

**Friday:** business attire

**Saturday morning:** casual

**Saturday reception/dinner:** coat and tie/dressy business attire or cocktail dress

**Sunday:** casual

### FRIDAY, SEPT. 9

7:00 am -	CMS Office opens
7:00 am - 5:00 pm	Registration
7:00 am - 8:30 am	El Paso County Caucus
7:15 am - 8:15 am	Reference Committee Breakfast
8:00 am - 12:00 N	Exhibits open
8:15 am - 8:45 am	Credentials Committee
8:30 am - 9:30 am	Alliance BOD Breakfast
8:45 am - 9:15 am	Opening Session -House of Delegates
9:15 am - 11:30 am	General Membership Meeting
9:45 am - 10:15 am	Coffee break
9:45 am - 11:45 am	Alliance General Meeting
12:15 N - 1:45 pm	COMPAC/Alliance Luncheon (Gubernatorial Candidate Debate)
-	
1:45 pm - 2:45 pm	Copic Risk Management
1:45 pm - 2:45 pm	Copic Risk Management
1:45 pm - 4:15 pm	Reference Committee
1:45 pm - 4:15 pm	Reference Committee
1:45 pm - 2:45 pm	Alliance Legislative "Know How" Workshop
2:00 pm - 4:00 pm	Army National Guard Physicians
2:45 pm - 3:45 pm	Copic Risk Management
2:45 pm - 3:45 pm	Copic Risk Management
3:00 pm - 4:30 pm	Alliance County Breakout Sessions
3:45 pm - 6:15 pm	Reference Committee
3:45 pm - 6:15 pm	Reference Committee
4:00 pm - 7:00 pm	Exhibits open

5:30 pm - 7:00 pm	Exhibitor Reception
6:30 pm - 7:30 pm	Colorado Society of Internal Medicine Annual Meeting
7:00 pm - 9:00 pm	Women in Medicine Meeting
7:00 pm - 8:30 pm	"Gone But Not Forgotten" Dinner

### SATURDAY, SEPT. 10

7:00 am -	CMS Office opens
7:00 am - 11:00 am	Registration
7:00 am - 7:50 am	Educational Program Continental Breakfast
7:00 am - 11:00 pm	Exhibits open
8:00 am - 11:30 pm	"Who's Looking at You?" Educational Program
11:30 am -	Recreation Time
-	golf, tennis, horseback riding, biking, fishing, walking, etc.
1:00 pm - 3:30 p.m.	Copic Seminar: "Danger: Health Care Reform May Be Hazardous to Your Financial Health"
1:00 pm - 3:00 pm	Army National Guard Physicians
6:00 pm - 7:00 pm	Inaugural Address
7:00 pm - 11:30 pm	Presidents' Dinner/Dance
8:30 pm - 10:30 pm	Copic Dessert Reception

### SUNDAY, SEPT. 11

6:30 am -	Reference Committee Reports available
7:00 am -	CMS Office opens
7:00 am - 10:00 am	Registration
7:00 am - 8:30 am	Component Caucuses
	Arapahoe
	Aurora-Adams
	Boulder
	Clear Creek Valley
	Denver
	El Paso
	Larimer/Weld
	Pueblo/Western Slope
8:00 am - 8:30 a.m.	Credentials Committee
8:00 am - 9:00 am	Alliance Gavel Club Breakfast
8:30 am - 12:00 N	Closing Session HOD
12:00 N (or immediately following HOD)	
-	Nominating Committee
12:00 N (or immediately following HOD)	
-	Reorganizational Board
12:00 N (or immediately following HOD)	
-	Army National Guard Physicians

# COMMITTED TO EXCELLENCE



## ROCHE LABORATORIES

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*Please join us in honoring these outstanding Roche representatives who have distinguished themselves by a truly exceptional level of professionalism, performance and dedication to quality health care. Throughout the year, each of these award-winning individuals has consistently exemplified the Roche Commitment to Excellence and we're proud to invite you to share in congratulating them on their achievement.*



Linda Coleman  
Colorado Springs, Colorado



Edward Exum  
Denver, Colorado





# Abstinence the Best Policy

## Physicians advised to avoid alcohol use in connection with patient contact

Steven L. Dilts, MD, Medical Director of the Colorado Physician Health Program (CPHP), has spent years educating physicians on the dangers of the use of alcohol and drugs in medical practice. He has written a couple of articles on the subject for *Colorado Medicine* (1988:508 & 1990:337) in which he explains that even moderate use of alcohol can significantly impair the effectiveness of a physician.

Now Dr. Dilts has passed along a report from the AMA House of Delegates (Board of Trustees Report Y, June 1991) which gives a scientific basis for these concerns. Several studies were examined for information on physician impairment through the use of alcohol.

### Psychological Impact

Both Dr. Dilts and the AMA report raise serious concerns about the psychological impact of alcohol use on the physician-patient relationship. Dr. Dilts mentions the emotional impact on a patient smelling alcohol on the breath of a physician. The AMA report says, "Few would argue that the physician-patient relationship may be eroded if the patient suspects that the physician has recently ingested alcohol (e.g. from breath odor or behavioral changes). On that basis alone, regardless of the actual effect of alcohol ingestion on the functioning of the individual physician, it would behoove the physician to avoid alcohol intake in temporal proximity to encounters with patients."

### Physical Effects

The AMA report notes that there are no studies on the acute effects of alcohol on physician performance per se. However, several other studies can shed some light on the subject.

A blood alcohol content (BAC) of 0.04 percent (40 mg/dl) would be produced in a 70 kg (156 lb) person who consumes two standard drinks in an hour (a standard drink is 1 oz. of 80 proof liquor, 12 oz. of beer or 4 oz. of wine). Twenty five percent of the studies reviewed found impairment of driving skills at that level and the majority of studies found impairment at least by 0.07 percent (70 mg/dl). One study provided evidence that some impairment of function occurred at the lowest BAC studied (0.015 percent or 15 mg/dl), lending credence to the idea that there is no discernible threshold below which no impairment occurs.

Of course, the effect of alcohol on performance is highly individual, but research does indicate that the effects of impairment are greater when higher cognitive or intellectual functions are involved. In a study of managerial performance by people with proven skill and success, a BAC of 0.05 percent (50 mg/dl) and 0.10 percent (100 mg/dl) had an adverse impact on high level strategic planning and complex cognitive activities. The parallels between that and the observation, diagnosis, treatment, monitoring and adjustments necessary in medical practice seem quite striking.

Another significant physical

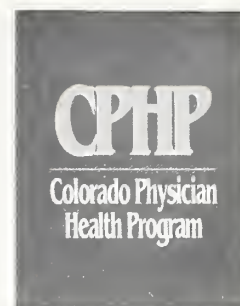
effect of alcohol is the "hangover" effect from intoxication. This requires a higher BAC and can be mitigated by acquired tolerance, but its effects linger quite a bit longer than those of the alcohol itself. A BAC of 0.04 to 0.08 percent (80-100 mg/dl) would probably not produce hangover effects and in about four hours (given an average rate of alcohol metabolism of 8.4 g per hour or a decline in BAC of 22 mg percent per hour) the BAC and/or body content of alcohol would approach zero.

On the other hand, a BAC of .15 percent (147 mg/dl) can produce significant impairment of motor skills the next morning. Studies of both automobile driving and Navy pilots flying a simulator showed degraded performance the morning after intoxication (14 hours after, in the case of the pilots).

### Guidelines

The Federal Aviation Administration (FAA) currently requires an 8 hour interval between alcohol intake and flying and allows a BAC as high as 40 mg/dl (0.04%) at flight time by pilots. Some have suggested lowering the BAC as well as lengthening the interval to account for the "hangover" period. One review of anesthesiologists performance raised the question of whether they should be held to a similar standard.

While none of these studies can be directly applied to physician performance under the influence of alcohol, they certainly give some indications of how physicians should regulate their use of alcohol. In Report Y, the AMA urges that "physicians engaging in patient care



have no significant body content of alcohol," and that "all physicians, prior to being available for patient care, refrain from ingesting an amount of alcohol that has the potential to cause impairment of performance or create a 'hangover' effect."

The AMA notes that the "possibility, or even the perception, of any

alcohol-induced impairment of patient care activities is inconsistent with the professional image of the physician."

Dr. Dilts says, "I would hope that all physicians would take this report and recommendations to heart and seriously look at their personal use of alcohol as well as other mood altering drugs, including prescription medications, while on duty."

*"I would hope that all physicians would ... seriously look at their personal use of alcohol."*

**Steven Dilts, MD**

## CPHP Initiates Family Services

What happens when the doctor gets sick? In the case of a serious illness, but also when the problem is "just" burnout or stress, not only is the physician affected but also the physician's family or other significant relationships. Likewise when serious illness strikes a member of the family, the physician has multiple concerns and may need help or support. Thus, illness directly affects the identified patient, but all important relationships feel some impact.

The Colorado Physician Health Program (CPHP) has long recognized this reality, but only recently was provided the resources to offer explicit programming to assess and meet the needs of physician families (and significant others). CPHP also recognizes that physicians and their family members often find it hard to know when, how, or where to get help. Because of the cultural perception that physicians (and by extension, family members) "have it all", there are sometimes subtle, or no-so-subtle, barriers to recognizing and obtaining effective care and support for health problems.

Not the least of these barriers is the stigma of "needing help", or the fear that such a need could adversely affect the physician's career. In fact, ignoring or denying the presence of a health problem is seldom a successful strategy for taking care of the illness or for maintaining a medical practice. CPHP offers confidential (unless patient safety issues occur) and specialized program services for physicians and family members. Initial telephone consultations/problem solving can be anonymous, if the caller wishes.

CPHP's family component offers the following specific services:

- Personal consultation and assessment of the family member's individual needs, as well as any special issues related to the physician's health problem.
- Referral to counseling or other resources to address identified needs, and follow up to assure that referrals are helpful.
- Educational presentations to spouse/family organizations regarding physician/family health issues.
- Liaison with community resources to identify effective options for physician family members.
- Liaison with community resources to develop new programs to meet the needs of physician family members.

Note: A Spouse Support Group has been formed for Colorado Springs and the southern Colorado area. Spouses/significant others wishing to obtain more information, or to arrange a personal consultation, may contact Dorothy Moffet, Assistant Director for Clinical Services, 860-0122 (metro-Denver) or 1-800-927-0122 (toll free).





Edie K. Register, Director  
Health Care Financing Department

# Abusive Beneficiaries

*You suspected something  
was wrong...*

The Medicare Fraud Unit has the responsibility to investigate and refer cases involving not only providers who defraud the Medicare Program, but also beneficiaries who are involved in activities to obtain services inappropriately. The Colorado Carrier is currently working several cases with the Office of the

Grant Steffen, MD, Medical Director  
Colorado Contractor, Medicare Part B

Inspector General involving beneficiaries who make a practice of visiting emergency rooms or physicians' offices with a complaint of symptoms or recent injury in an effort to obtain narcotic medications. These sometimes go to a different provider daily or multiple providers on the same day. The complaints to each provider are usually similar in nature, and the beneficiaries are willing to expose themselves to repeated X rays in an effort to ultimately receive prescription medications.

Some of these beneficiaries are traveling to multiple states in order to decrease the likelihood of being caught. Physicians are put in the difficult position of having to treat these beneficiaries, at least initially.

Through working these cases, it has become apparent from contact with some of the treating physicians, that many providers have been suspect about these patients, but were unaware of where to report their suspicions. If you have reason to feel that a patient is abusing your services and the Medicare Program, you may contact fraud unit personnel at 303-831-3024. We will research the beneficiary history here in Colorado, and perhaps with neighboring states to see if the patient is visiting multiple providers. You will need to identify the name, Health Insurance Claim number, and the diagnosis for which you treated the patient in order for us to pursue our investigation.



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*The positive continuing education alternative for physicians*

For more information, write or call:

**CPEP**

5575 DTC Parkway, Ste 350-A  
Englewood, CO 80111  
(303) 773-0440

The key focus of CPEP is to offer a positive educational experience based on the individual's learning style and clinical knowledge. A variety of learning resources will be identified for the physician to utilize, ranging from personal mentors, computer-based learning, class lectures, skill development and communication training.

## BOARD HIGHLIGHTS



### Highlights of Board of Directors Meeting March 4, 1994

- CMSA:** Ms. Patti Brown, President, announced that the Larimer County Alliance has received a community service award for their project of funding a school based clinic staffed by a nurse practitioner.
- AMA Delegation:** Dr. Karlin reported that the Colorado Delegation has submitted several resolutions to the AMA House of Delegates Annual Meeting.
- COMPAC:** Dr. Sawyer reported that there will be many changes in the political candidates in the upcoming election. He urged a greater participation in COMPAC by the CMS membership.
- Board of Directors:**
- The Board approved a motion to instruct the Health Affairs Council to develop a white paper on the subject of selective contracting in the HMO arena.
- The Board heard a report from the Membership Department on the recruitment efforts to increase the membership of CMS currently underway in the Department.
- The Board approved a motion to ask the Council on Ethical & Judicial Affairs to review the AMA Sexual Misconduct Policy for possible inclusion in the CMS Policy Manual.
- The Board approved the actions of the Executive Director in indicating to the AMA that CMS would be a cosponsor of the response by the AMA to the letter sent to the Congress by a coalition headed by the "BIG FIVE" insurance companies.

## COCHEM'S TRUST FUND

The Cochem's Trust Fund was created to assist Colorado Medical Society physicians in need of financial assistance. Monies are given only to the physician (not to the family or estate) and the request must be accompanied by two supporting letters from physicians briefly explaining the nominated physician's background and the circumstance(s) indicating that he/she should receive financial support from the Trust.

If you are aware of a physician in financial need who meets the criteria listed below, please call the CMS office. The criteria are that the physician:

- 1) Must be a member of the Colorado Medical Society
- 2) Must be a medical doctor licensed by the State of Colorado
- 3) Must be a resident of the state of Colorado for at least ten years





### Stout Street Benefit Run

The students of the University of Colorado Health Sciences Center are planning the third annual Stout Street 5K Run/Walk to be held on Saturday, September 10, 1994 at City Park in Denver.

The event will benefit the Stout Street Clinic, a medical facility which provides comprehensive health care for the homeless and economically disadvantaged populations in Denver. Stout Street Clinic, one of the many projects headed by the Colorado Coalition for the Homeless, is funded by Public Health Services, grants, and in-kind and monetary donations.

The Stout Street Run affords the students of the University of Colorado Health Sciences Center the opportunity to raise funds to monetarily support the clinic, in addition to providing a forum through which we can increase awareness of the medical problems facing the homeless individuals and families in our community.

We are asking for your support in any of the following areas: PERSONNEL (manpower) on race day, MONETARY DONATIONS, PARTICIPATION as a runner (entrance fees have not yet been established; however, in the past, they have averaged \$15).

Your help in supporting our cause would be greatly appreciated. Those sponsors making a donation of \$100 or more will be acknowledged on the race application, T-shirts, and publicity. If needed, the UCHSC

nonprofit numbers are 9800799 (state) and 8470123K (federal).

We and the clients of the Stout Street Clinic appreciate your generosity. Please feel free to contact Shawna Harris, Student Senate President and Stout Street Run Coordinator, at 270-8254 if you have any questions or would like more information about the fun. Any correspondence can be sent to the UCHSC Student Senate c/o Shawna Harris at 4200 E 9th Ave. Box A043, Denver CO 80262. ***Please advise of your intent to help with the run by August 1, 1994.***

On behalf of the students of the University of Colorado Health Sciences Center, "thank you" for your consideration! Your donation is representative of the awareness and support that help to alleviate the problems faced by the homeless populations in our community.

### Informatics Fair

On Thursday and Friday, September 29-30, Denver Medical Library will be hosting the Second Annual Informatics Fair. Exciting new technologies will be demonstrated in the library, including practical applications for medical practice management and patient record software. The keynote speaker will be Michael Ackerman, PhD, from the National Library of Medicine in Bethesda. Look for upcoming announcements about speakers, workshops and telemedicine.

### Minors now eligible for CPR Directives

Just when you thought you understood what to do when a patient asked for a CPR Directive, this law which allows persons to refuse CPR has been amended.

Initially, only individuals 18 years or older, or their agent in the event that an individual lacks decisional capacity to provide informed consent, could execute a CPR Directive.

**The law now allows the parents or guardian of a minor child to execute a directive on the child's behalf, providing that a physician has previously issued a do not resuscitate order for the child.** The law further describes the parents and guardians as "those married and living together, the custodial parent, or the legal guardian".

Further changes in the law clearly define who can revoke a CPR Directive as "only those CPR Directives executed originally by a guardian, agent, or proxy decision-maker may be revoked by a guardian, agent, or proxy decision-maker. In other words, if you didn't make it, you can't break it. Directives may be revoked by one of two ways; physically canceling or destroying the CPR Directive forms and bracelet or necklace, if used, or by an oral expression by the patient, or by the agent speaking for the patient.

Any questions regarding CPR Directives should be directed to Marilyn Barton or Ellen Stein, 779-5455 or 1-800-654-5653. An information packet will be mailed to you upon request.



## Recent Changes to the Code of Colorado Regulations

The Board of Health recently passed the following amendments to the regulations pertaining to infant immunizations:

1. The recommended age for the third dose of oral polio vaccine was lowered from 18 months to a range of from 6 - 18 months. This change became effective May 1, 1994.

2. The fourth dose of whole cell DTP or DTP/HIB combined vaccine can be given as early as 12 months provided the interval between DTP dose three and four is no less than 6 months. DTaP cannot be given before 15 months of age and is recommended only for the fourth and fifth DTP doses; whole-cell DTP or DTP/HIB combined vaccine should be used for the first three shots in the DTP series. Effective July 1, 1994.

3. After the primary infant HIB series is completed, any HIB vaccine may be used for the booster dose at age 12 - 15 months. Effective July 1, 1994.

4. Combined DTP/HIB vaccine may be used for the 4 dose HIB schedule. Effective July 1, 1994.

## Update on OSHA Regulations

In March, 1994, *Colorado Medicine* (page 107) reported on a number of antimicrobial sterilants which were

found to be ineffective, but still registered by the Environmental Protection Agency. We have since received more information on one of the products listed.

According to Metrex Research Corporation, the manufacturer of several of these products, one of them, MetriCide 28, has now been returned to the EPA list of approved antimicrobial agents, provided the label includes a sterilization temperature of 25°C, rather than 20°C, as previously stated. Metrex is placing stickers on the containers of MetriCide 28 which tell of the new sterilization temperature.

This applies only to MetriCide 28 (EPA Registration # 46781-2). Metrex is working with the EPA to return MetriCide (#46781-1) and MetriCide Plus 30 (#46781-4) to the list. MetriCide Plus 14 (#46781-3) has been voluntarily recalled from the market.

## Interpreters for Hearing Impaired Patients

The two following interpreter referral organizations may be of interest to physicians who have, or may at a future point in time have hearing impaired patients that require an interpreter. Both organizations are located in the Denver-metro area.

**HSI** - 321-4906

\$32 per hour between 7:00 a.m. and 10:00 p.m.

\$42 per hour between 10:00 p.m. and 7:00 a.m.

**Center on Deafness** - 839-8022

\$36 per hour between 7:00

a.m. and 10:00 p.m.

\$54 per hour between 7:00

a.m. and 10:00 p.m.

Both agencies:

1. have a one hour minimum
2. calculate rates in quarter hour increments after the first hour.
3. ask that in addition to providing them with the date, time and place of the service that you supply them with the patient's name, a contact person and phone number and information about the situation (i.e. is it an appointment, surgery, a follow-up, etc.)
4. ask that requests for interpreting services be made three working days prior to the date the services are needed (one week is preferred) However, every effort will be made to provide services when less notice is given.
5. require that cancellations be made at least 24 hours prior to the scheduled service. Cancellations with less than 24 hours notice will be billed in full.
6. require 2 interpreters when more than 2 hours of interpreting is needed. Under the latter circumstances the interpreters shift approximately every 30 minutes in order to provide optimal services. The billing for such services is the above-quoted rate per interpreter.

\*Often managed care organizations pay for these services; physicians should check with their organization.

\*According to Title 26, Internal Revenue code, section 44 Tax credits are available to small

PHOTO BY  
JIMMY  
HARRIS





# LET'S STOP BUILDING WALLS AROUND THESE KIDS.

These children are just like other kids except for one thing. They have epilepsy. You know that, while some need special help, they don't need walls.

Walls of misunderstanding, overprotection, or prejudice still keep kids like these in classrooms away from other children and exclude them from sports, trips and other normal school activities.

Help the Epilepsy Foundation of Colorado get rid of the walls around children with epilepsy or other disabilities — and count them in.



**Epilepsy**

FOUNDATION OF COLORADO

Get the facts. Call Epilepsy  
Foundation of Colorado at  
(303) 761-2742.

# Thinking About Travel?

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help you chart your course.

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businesses (those with gross receipts of less than \$1 million or those with less than 30 employees) in the amount of 50% of their total costs for complying with the ADA between \$250 and \$10,250. The cost of providing auxiliary aids, such as qualified interpreters for the hearing impaired, would be applicable toward tax credits in the above-mentioned circumstances.

ADDITIONAL INFORMATION CAN BE OBTAINED FROM:

The Job Accommodation Network for free information about accommodation strategies 1 800 526-7234

The Department of Justice's Americans with Disabilities Act Information Hotline 1 800-514-0301 voice or 1 800-514-0383 TDD.

### Patients Needed for Diabetes Study

The Denver Diabetes Center is conducting a study of patients with Type I diabetes (Insulin-dependent Diabetes Mellitus) on hemodialysis. The purpose of the study is to discover if control of blood sugar will delay or prevent further complications, improve medical management, quality of life and reduce cost of care in this population.

The study consists of two groups: an Intensive Insulin Therapy Group and an External Insulin-delivery Pump Group. Both methods are expected to control blood sugar and stabilize or improve health. Each patient is enrolled for one year.

The study is free of charge and

related supplied will be furnished. Enrollment is limited for this ongoing study funded by the Rose Foundation. The Research Coordinator, Helena Chung-Hawks can be reached at the Denver Diabetes Center, 303-3290-2960, for further details.

### Doctors inject funds into nursing program

*by Nancy Lofholm,  
Grand Junction Daily Sentinel*

Some aspiring nurses will have a sizeable portion of their tuition covered for many years to come, thanks to help from physicians in Mesa County.

The Mesa County Medical Society today was to present the Mesa State College Nursing and Allied Health Department with a \$9,000 check that will go into an already-established scholarship fund for nurses.

The doctors' donation will push the fund up to \$25,000 — enough to endow a foundation that will earn the interest needed to supply scholarships indefinitely.

"We really appreciate what the medical society has done. I help choose who will receive the scholarship, and I know how much it is helping my students," said Sherry Roy, chairwoman of the Mesa State associate degree nursing program.

Roy said the medical society and its auxiliary, the Mesa County Medical Society Alliance, started the scholarship fund several years ago. But until now, it didn't contain enough money to be self-perpetuat-

ing.

She said the foundation will give out one or two \$1,000 scholarships per year to help defray tuition costs, which now run about \$1,700 annually for nursing students.

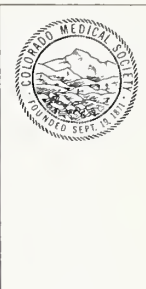
Roy said nursing students have always been at a disadvantage because, unlike other college students, they must attend school full-time. She said many nursing students are working parents who need help with tuition.

One reason the local doctors wanted to provide funds for nursing students at Mesa State was to encourage graduates to stay and work in the Grand Valley. Mesa State now has about 45 students in the two-year degree program, and about 100 students in the four-year nursing degree program. The programs have 20 openings for next year and there are already 70 applications for those slots.

### Are You Concerned About A Situation Involving Prescription Drug Abuse?

Information on existing resources is now available through **The Prescription Drug Abuse Hotline (303) 893-9112**. The hotline is staffed by pharmacists organized to assist professionals in dealing with situations related to prescription drug abuse.

The Prescription Drug Abuse Hotline is a cooperative effort of the Colorado Prescription Drug Abuse



Task Force, the Colorado Department of Health Alcohol and Drug Abuse Division, and the Rocky Mountain Drug Consultation Centers.

## Rx Drug Abuse Support Group

facilitated by a certified addictions counselor

is now available free of charge meets every Tuesday night from 7-8:30 p.m.

at Aurora Behavioral Health Hospital  
1290 South Potomac  
Aurora, Colorado

Sponsored by the Colorado Prescription Drug Abuse Task Force

## Physicians and Students Address Rural Medicine

One of the best ways to get students interested in rural medicine is to give them a chance to experience the rewarding experience of a rural lifestyle. At least that's the theory behind a program developed by the Colorado Medical Society and Dr. Richard Bakemeier of the University of Colorado School of Medicine.

Approximately forty students who are involved in fellowships at the medical school will be paired with rural physicians in the hope that they might be influenced to choose rural medicine as a career. Most of the students are in college, a few are in medical school and one or two are in high school. The visits to rural communities are an additional opportunity beyond the fellowships they are already doing.

If you, or a physician you know, would be interested in hosting a student in a rural setting, please contact Ellen Stein or Marilyn Barton at the Colorado Medical Society, (303) 779-5455 or 1-800-654-5653.

## Skin Cancer Awareness

It's that time of year again when physicians need to make sure their patients are aware of the risk of skin cancer. A recent screening in Denver, with 127 participants, revealed 5 Melanomas, 14 Non-melanoma skin cancers, 21 precancerous keratoses, and 17 atypical nevi. All were referred to a physician for further evaluation.

Barbara Reed, MD, a CMS member and past president of the Colorado Dermatologic Society, reminds physicians that "Except for freckles, sun damage doesn't show up for 20 years or more. People with skin cancers who are told they are due to the sun often comment that they haven't been in the sun for years. They don't realize that most of their sun damage has occurred before the age of 18."

According to Dr. Reed, the *Skin Cancer Foundation Report* shows that about 80% of adult skin cancer is due to sun exposure or a serious sunburn before the age of 15. She says, "Most sun damage occurs between the ages of 5 and 15, having a major influence on the development of skin cancer later in life. On the average, children are in the sun three times more than adults during the sun's strongest hours, 10 am to 3 pm."

Here are some tips physicians can

pass along to their patients (and set a good example in, also):

- Avoid excessive sunlight by planning outdoor activities in the early morning or late afternoon.
- Use sunscreens with a high SPF rating (15 or greater), applying them liberally every two hours to all areas not covered by your clothing.
- Wear hats, but remember, reflected sun can still reach your face. A 3-inch floppy brim hat is better than a ball-cap, which only protects your forehead.
- If you are wearing very light, gauzy clothing, or a loosely woven straw hat, you may sunburn through it and should apply sunscreen beneath.
- Keep a watchful eye on children and be sure they are wearing sunscreen too. Infants should be kept out of the sun entirely. It is a good idea to put a tube of waterproof sunscreen block in the child's backpack and remind them to reapply the sunscreen throughout the day.
- Be sure to wear sunglasses. Also, make certain your children wear sunglasses too. Excessive sun exposure to the eyes causes cataracts.

## Smoking Cessation Kits Available

As part of their anti-tobacco initiative, the American Medical Association is featuring a smoking cessation kit. The kit, entitled, "How to Quit" includes an instructional





video tape and companion handbook, audio tapes for both stress management and support, a weekly performance calendar and a smoker's diary. Also provided are specific instructions on how to prevent relapse and weight gain as well as access to a 24-hour toll-free support line.

The video features a series of "house calls" by a team of medical experts led by Edward A. Taub, MD, a family physician and smoking cessation advocate from Mount Carmel, Ill.

"How to Quit" is cosponsored by campaign creator, Orbis Direct, L.L.C., and the General Nutrition Center, the national sponsor and exclusive retailer of the kit.

Kits are available for \$69.95 at all of the General Nutrition Center stores in Colorado. Stores are located in: Grand Junction, Colorado Springs, Fort Collins, Pueblo, Boulder, Greeley, the Denver-metro area, Loveland and Longmont.

AMA royalties from kit sales will be used exclusively to fund campaigns to combat domestic violence, substance abuse, tobacco smoking, AIDS and similar public health problems.

### Medical Journals Received

Your Colorado Medical Society currently receives medical journals from all over the world. They are contributed to the collection of the Denver Medical Library (303-839-6670) for the use of our members and other Colorado physicians.

Two journals we thought you might have interest in are the *Tohoku*

*Journal of Experimental Medicine* and the *Western Journal of Medicine*. Each accepts submissions for scientific articles from physicians in various specialties and geographic areas, filling a need which was once met by the *Rocky Mountain Medical Journal*, which ceased publication in 1979.

The *Tohoku Journal of Experimental Medicine* is published monthly in three volumes containing four numbers each year. It is open to original articles in all branches of medical sciences from authors throughout the world. Case reports which advance significantly our knowledge on medical sciences or practice are also accepted. Review articles will also be considered.

*Western Journal of Medicine* is the official journal of the Alaska State Medical Association, the Arizona Medical Association, the California Medical Association, the Denver Medical Society, the Idaho Medical Association, the Nevada State Medical Association, the New Mexico Medical Society, the Utah Medical Association, the Washington State Medical Association and the Wyoming Medical Society. It is published monthly in two volumes, beginning in January and July.

Contact the *Tohoku Journal of Experimental Medicine* for subscriptions by writing to Maruzen Company, Ltd., PO Box 5050, Tokyo International 100-31, Japan or for submitting manuscripts to Tohoku University Medical Press, Tohoku University School of Medicine, Aoba-ku Sendai, 980, Japan.

Subscription information for the *Western Journal of Medicine* is

available by writing to the Circulation Department at PO Box 7602, San Francisco CA 94120-7602, phone (415) 882-5179. Information for authors is obtainable from the same address, but the phone number is (415) 882-5177.

### Portents of National Health Care?

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) now has the authority to review all claims for health services under their program for quality of care and appropriate utilization. This authority was granted by a regulation promulgated by the Department of Defense in November, 1993.

According to CHAMPUS, "This means that providers who submit claims must provide all requested information necessary to conduct reviews."

CHAMPUS has awarded a contract to review claims for mental health services to Science Applications International Corporation. SAIC will review the medical records to evaluate the "completeness, adequacy and quality of care." CHAMPUS will reimburse the physician the same as Medicare does, for first-class postage and 7¢ per page photocopying charge.

Want more information? Call the Mental Health Program Branch at CHAMPUS headquarters at (303) 361-1184.

# NEW MEMBERS



## ARAPAHOE MEDICAL SOCIETY

Cynthia I Blake, MD  
825 Dahlia St #301  
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Elected 03/17/94

Martin Boublik, MD  
8200 E Bellview Ave #615  
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Scott P Falci, MD  
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Elected 04/19/94

Sharon D Freeman, MD  
206 S County Line Rd #110  
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Elected 04/19/94

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Jeffrey B Hanson, MD  
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Elected 02/15/94

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Jason D Sutherland, MD  
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Elected 05/17/94

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Longmont, CO 80503  
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Patrick A Finnegan, MD  
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Karen E Leonard, MD  
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Laura T Sample, MD  
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Boulder, CO 80304  
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Michael A Zeligs, MD  
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Diana L Edenfield, MD  
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Mary F Ostermann, MD  
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Elected 08/19/93

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Elected 03/18/94

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Denver, CO 80220  
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2750 S Dayton Way #G311  
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Elected 06/03/94

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Wayne K Gersoff, MD  
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Robert J Foster, MD  
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Mark B Hazuka, MD  
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Arlene E Hudson, MD  
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Douglas J Raskin, MD  
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A Thomen Reece, MD  
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William R Schroeder, DO  
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Colorado Springs, CO 80910  
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Mark W Walton, DO  
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790 Wellington Ave #202  
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Gayle P Miller, MD  
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Elected 11/01/93

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Greeley, CO 80631  
Elected 09/01/93

H Daniel Fahrenholtz, MD  
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Greeley, CO 80631  
Elected 03/18/94

Velusamy Kailasam, MD  
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Ft Collins, CO 80524  
Elected 02/01/94

Eric D Reitz, MD  
Greeley Med Clinic  
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Greeley, CO 80631  
Elected 02/18/94

Charles I Zucker, MD  
1650 16th St  
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**NATIONWIDE** - Opportunities for the following: IM, DP, OB/GYN, PED, ONC, CD, and more. Send CV to Stan Kent, Stan Kent & Associates, PO Box 904, Tremont IL 61658 or call 800-831-5679, FAX (309) 952-5842. 22/594

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by Thomas H. Coleman, M.D.  
Denver

### ***"Dr. Craig's old house was smashed and carted away . . ."***

Though I'm no Gene Amole, having watched nearly a half-century of Denver's history and growth I feel like a native. The day I arrived here "The Stack" was dynamited at the gold smelter on North Washington. I was here the week the great elms of old Court House Square were cut down for Zeckendorf Plaza, the year the old Denver Club was demolished and raised to Heaven by the angel Murchison, the day Sears Roebuck and the Blue Parrot Restaurant were leveled for I. M. Pei's Mile High Center. Dr. Craig's old house was smashed and carted away for the excavation of Denver's nuclear-bomb-proof Farmer's Union. The Arneill Clinic, near H. A. W. Tabor's old house, gave way to a bank. I have watched the demolition of the "new" headquarters of the Denver Medical Society and the flattening of Grasshopper Hill to make way for Presbyterian /St. Luke's, the dilapidation of the old Colorado Medical Society headquarters for a new cancer treatment center. From just one golf driving range I have seen three colossi rise to become the Veterans' Hospital, the new University Hospital, and the Barbara Davis Institute.

Older Denverites may remember those old places. What surprises me is that they don't know of a strong and illustrious survivor of all that destruction, the Webb-Waring

Institute. Most doctors know, but when I mention Webb-Waring outside the community of Denver medicine the response is "Oh? What's that?" It's time they knew.

The institute was founded in the 1920s by two outstanding physicians, Dr. Gerald Webb and Dr. James J. Waring, for the study and treatment of tuberculosis. They and Dr. Henry A. Sewall did pioneer work, saving the lives of thousands of patients. They were some of the first to see the importance of immunology, working and hoping to discover a TB vaccine. The Webb-Waring Lung Institute is now the Webb-Waring Institute for Biomedical Research, internationally recognized as a star in world science. Its last six years is a remarkable story of discovery and growth.

It is on the leading edge of research into the role of antioxidants in disease. Feature articles in the New York Times, the Wall Street Journal, The New England Journal of Medicine, the Rocky Mountain News, the Journal of the AMA all report the general excitement about antioxidants and health. If you buy a bottle of vitamins in a supermarket or see it advertised on television the label boasts of antioxidants.

They are all boasting about basic research at Webb-Waring. Investigators here are turning up scientific evidence of an ideal balance in the human body between harmful superoxides and healing antioxidants. A tilt of that balance in direction impairs our systems of immunity. Probably it is what's wrong in several diseases that might appear unrelated. The mental

retardation of Down syndrome, Lou Gehrig's ALS, multiple sclerosis, and a respiratory distress syndrome that kills some newborns or some people infected with the new hantavirus.

Correcting the imbalance may prevent some kinds of heart disease.

This does not mean Webb-Waring research has proven that a supermarket bottle of vitamins will prevent or cure those diseases or exempt you from a heart attack. It does mean that the Institute's research team is working on ways to locate the chromosomes and gene markers that screw up the balance of superoxides and antioxidants. Preventives and treatments may follow, possibly even for Webb-Waring's continuing interest, tuberculosis.

Supported in part by NIH grants, the team of 14 men and women scientists led by Doctors John Repine and Joe McCord is doing intensive work in that direction. In March two other internationally recognized scientists reviewed Webb-Waring research. Their report is full of praise and enthusiasm. They recommended the Institute recruit a third principal researcher trained in genetics and immunology. A campaign to raise the money needed for that person is beginning.

The Webb-Waring Biomedical Research Institute is on the Denver campus of the University of Colorado Health Sciences Center, in its own building, next to the Belle Bonfils Blood Bank. The Director is John M. Repine, M.D. His secretary, Ginny Parker, will be glad to send you more information when you call 270-8231.



# COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

1994

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Volume 91, Number 8

STACKS

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"Some are saying  
'Health Security Express'  
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(Denver, CO) **Health Caravan Arrives In Denver.** Three motor coaches labeled "Health Security Express" arrived in Denver July 26th at 5:00 p.m. on their way from Oregon to Washington, D. C. The buses were part of a nationwide Clinton Administration effort to get his Health Security Act passed in this session of Congress. In Denver, the caravan was met by supporters and protesters alike. **Colorado Medicine** covered the arrival (and demonstrations).

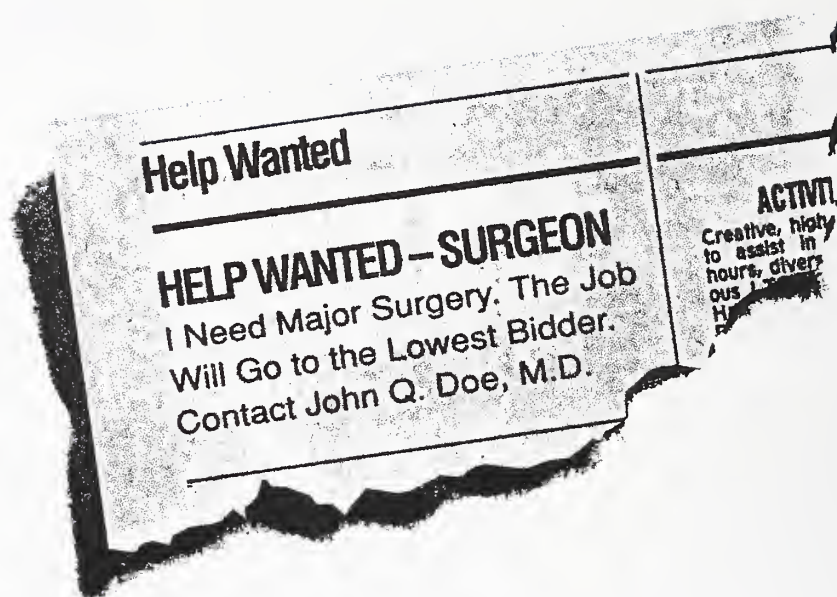
See MED-FAX picture and story coverage in this issue.

STACKS

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# COLORADO MEDICINE

August, 1994

Volume 91, Number 8



## Cover Story

There are many varied opinions about Health System Reform, as evidenced recently in Denver. See Med Fax in this issue.

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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Michael Thompson, Asst. Managing Editor; Gil Maestas II, Communications Specialist



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Wm. Carl Bailey, MD  
President, 1993-1994

## Health System Reform and Chaos Theory

Almost everything lately seems to make me think of Health System Reform. I have been attending a number of conferences on the subject and listening to a lot of experts. Most of them say the same things, push the latest version of "integration" and seem as unable to predict the future as the rest of us. They remind me of a swarm of blackbirds, whirling and swooping together in unison ... in a totally random manner. Perhaps in part because of this, a recent article on Chaos Theory piqued my curiosity.

The article appeared in the *Wall Street Journal*, July 11, 1994, written by Dennis Farney, and deals with what some describe as the incredible unraveling of the very basis of Western thought — the philosophy of secular, or rational humanism. This product of the "Age of Enlightenment", is based on the premise that nature is inherently orderly, and that if one can but understand the Natural Law, and apply the tools of reason and technology, problems can be solved, progress made, and the world made better and better. Under its rubric, education and technology will inevitably produce a better life, and Congress can effectively change human behavior by such things as enacting a crime bill. Rational Humanism has long had its critics, among them religious traditionalists. Even its critics have to admit that it has promoted the values of human dignity, tolerance and individual freedom. But all of this, says Farney, must be weighed against its dark side, its "overweening hubris".

Now, say some commentators, our supreme confidence in ourselves

and in the philosophy of secular humanism is eroding. They propose that Western culture and thought are at a crossroads, and their very foundations are being shaken. David Ehrenfeld, author of "The Arrogance of Humanism", is quoted in the article as saying "The idea of 'progress' is the disease of our time. In truth we are not inventing our future; we are just engineering changes whose outcomes we cannot predict, and which often turn out to be terrible".

What philosophy will replace secular humanism is by no means clear. However, one of the eroding forces in this loss of faith in rational humanism, and the alleged unhinging of Western thought, appears to be a growing acceptance of Chaos Theory. This holds that, far from Nature being inherently orderly, it is inherently disorderly. Change, flux, flow, and disorder are the norm, not harmony and progress. Chaos Theory states that long-term behavior of a system cannot be predicted with certainty unless the initial conditions of the system can be known to an infinite degree of accuracy, which is impossible. This is true of the weather or even human history. One of the ecologists who espouses the concept is Donald Worster, an ecologist who concludes that even a forest is not a harmonious orderly place, but more like a random collection of entrepreneurial individual plants. The world according to Chaos Theory is full of random events and unintended consequences.

Evidence of this sort of disorder is abundant in this century, both in

***"Democracy is the theory that the voters know what they want, and deserve to get it good and hard."***

***George Bernard Shaw***

(Continued on following page)



## PRESIDENT'S LETTER

(Continued from preceding page)

nature and human history. One need only consider the great natural disasters we have experienced; then add pollution, destruction of the rain forest, global warming, two world wars, communism, the holocaust, nuclear weapons, and currently genocide and fratricide in Bosnia, Rwanda, Somalia, and Haiti. Last year at the AMA Leadership Conference, Haynes Johnson (national columnist and commentator) brought home to us the huge problems afflicting our country — crime, violence, and the widening gap between classes. The diversity which was once such a strength of American culture has become, instead, a divisiveness of race, language, culture, and values. Some are afraid that it may lead to civil war. With all of this is a frightening decline in confidence in all of our institutions: government, law, education, religion, business, the press, and now, medicine.

What does this discussion have to do with health system reform? I think there are some obvious applications, as Administration and Congress hammer out health system legislation. One such application is the need to recognize, and be humbled by, the fact that not everything in life can be controlled, in spite of bureaucratic intent. There is a level of randomness (sheer cussedness) about human behavior and our world which is completely unpredictable. Ultimately, like Donald Worsters' trees in the forest, we may, after all, be a random collection of entrepreneurial individuals. Whatever plan is developed must be designed to help people help themselves. We must assist people to autonomy, demanding that each should be free to make decisions for himself, but also, to the extent he can be required to, be responsible for himself. Secondly, we must be careful not to over-engineer the system. It is not possible to design a system which will meet every contingency, nor every medical need. There is hubris (read: arrogance, insolence, supreme self

confidence) in politicians, expert consultants, and others, including ourselves, who believe huge problems can be solved with the stroke of the pen. One has only to recall the excesses and the misguided direction of some elements of the Social Security and Medicare programs, as well as other non-means-tested entitlement programs.

I cannot accept a totally random universe. Einstein, whose discoveries owed so much to the 'uncertainty principle' was appalled at the idea. In a now famous quote, he said "God does not play dice". The need for reform has grown slowly but steadily, and is real. We are obligated to do our best to deal with it. Because of a variety of (correctable) factors, most peoples' health insurance is attached to employment. The "crisis" grew out of an economic recession which precipitated anxiety by and for the unemployed/uninsured, and the "nervous/insured and underinsured". We are facing a situation where one-seventh of the GDP of the nation is at stake. At this

time, it appears that we are about to tinker with the entire system, to go from the present 85% of the population which is insured (most of whom are reasonably happy with their care) to one in which about 95% will be insured. There are some problems which need to be addressed, such as universal access/coverage, portability, non-cancelability, no preexisting conditions, and community rating. The welfare system profoundly affects the entire equation, through all layers. In the last election the winners cried "It's the economy, stupid!". In the next, it may well be "It's the welfare, stupid!".

In a recent talk, Alain Enthoven said that "incrementalism is the way democracy works.". I think he is right on that score. I hope our politicians swallow their hubris' and don't become stamped by a sense of crisis fueled by an impending election. I hope they are mindful of the potential for unintended consequences as they consider "the greatest social experiment in our history."

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## EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney  
Executive Director  
Colorado Medical Society

All it takes is "one person" with one thought or one belief. That's what makes organizations like Colorado Medical Society successful and effective. The only problem is that most of us wait for that **other** "one person" to express the thought or belief. We would rather "let someone else do it".

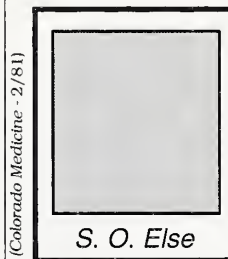
If we look at CMS in a very simplistic way and say we have 4,712 "one persons" and if we could inspire each of them to express that one thought or belief about their own situation in today's medical practice field . . . Wow!

You'll notice the plethora of letters to the editor (and others) printed in this issue, and that's a very healthy situation. That's what this journal is for: the expression of opinions, the reporting of events and the many other matters which impact the practice of medicine. A person has to presume that things are going along pretty smoothly when we see so few member opinions expressed in this journal and I, for one, would like to urge the CMS membership to start using this channel to express themselves. One of our editors (who shall remain nameless) who has been around for some time brought to my attention an obituary which was published in the journal a number of years ago (reprinted on this page). It was right after the first major "malpractice insurance crisis" had settled in and CMS started to deal with it, eventually creating the highly successful Copic Insurance Company. CMS membership knew someone was handling the crisis, and we developed a kind-of laid-back attitude, waiting for the next crisis. CMS has gone through numerous crises since then, and each one has become a little more severe. This one promises to outdo them all, and you'd better be involved.

You'll also notice that the letters in this issue expound on solid **differences of opinion**, also a very healthy organizational position as long as the persons openly express those differences. This is the essence of communication: open expression of differing views. This journal is not just a pipeline from the organization to its members; it is (or should be) a two-way conduit.

**And, don't forget:** we're holding an Annual Meeting September 10-12, 1994 for just this purpose... to tell the House of Delegates how Colorado's organized medicine should operate. It's your club, so **get involved!**

### ***CMS Mourns Loss of Long-Time Member***



The Medical Society was saddened to learn this week of the death of one of our medical community's most valuable members, Someone Else.

Someone's passing creates a vacancy that will be difficult to fill. Else has been with us for many years and

for every one of those years, Someone did far more than a normal person's share of the work. Whenever leadership was mentioned, this wonderful person was looked to for inspiration as well as results: "Someone Else can work with that group." Whenever there was a job to do, a resident to teach, a meeting to attend, one name was on everyone's list — "Let Someone Else do it." It was common knowledge that Someone Else was always the one who was happy to see the unfortunate patient with no income or insurance. Whenever the society was called upon to support a charitable or community project, everyone just assumed that Someone Else would provide what was needed. Someone Else was a wonderful person — sometimes appearing superhuman, but a person can only do so much. Were the truth known, everybody expected too much of Someone Else. Now Someone Else is gone! We wonder what we are going to do? Someone Else left a wonderful example to follow, but WHO is going to follow it? Who is going to do the things Someone Else did? When you have a chance to participate in the society activities, REMEMBER — we can't depend on Someone Else any more.

Now that Someone Else is no longer available.... perhaps you would like to become involved in your local and state medical society. You can make the decision right now to participate actively, not just pay dues and have no say. Organized medicine needs your say today more than every before. Medicine is no longer a place where you can "Let Someone Else do it".



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help to evaluate your financial ability to purchase the practice as well as to verify the accuracy of the seller's financial statements. Determine the most advantageous payment method from a tax standpoint. Find out why the owner wants to sell. Consider whether expansion of patient load and employees is feasible or constrained by size of the medical facility and zoning considerations.

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For further information, please contact:

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# Speakers for Educational Program

## Gerry L. Kaveny

Gerry Kaveny retired at the end of 1993 after a 25-year career with Coors. His final position was Executive Vice President of Administration and Finance for Coors Brewing Company. His responsibilities included finance, human resources, information services, strategic planning, purchasing and materials management. He also served on the Coors Board of Directors for 4 years.

He has actively participated in several civic organizations including Red Rocks Community College Advisory Board; Lutheran Medical Center Board of Directors; National Chairman of CUE, a subsidiary organization of the National Association of Manufacturers; and President of the United Cerebral Palsy Association of Denver.

He has been a Commissioner on the Colorado Health Data Commission for 4 1/2 years and is in his third year of serving as its Chairman.

## Peggye Wilkerson, RN

A graduate of the University of Arkansas School on Nursing (BSN 1972), Peggye Wilkerson worked in Little Rock, Arkansas, prior to joining the Denver office of the Health Care Financing Administration (HCFA) in 1985. She is currently Assistant Associate Regional Administrator, Division of Health Standards and Quality for the Denver Region Eight Office of HCFA.

## Warren R. Federgreen, MD

Warren R. Federgreen, MD, received his medical degree from Yale University, School of Medicine. He completed his postgraduate training at Bellvue Hospital, New York Medical Center, Yale University School of Medicine and was a National Institutes of Health post-doctoral research fellow.

Dr. Federgreen has been a practicing endocrinologist since 1985.

Dr. Federgreen currently serves as the Florida Medical Association representative to the Florida Blue Cross/Blue Shield Carrier Professional Advisory Committee. He has served for three terms as a member of the Florida Medical Association Blue Cross/Blue Shield Medicare Oversight Committee and serves as the Florida Medical Association representative to the State of Florida Agency for Health Care Administration Fraud and Abuse Task Force. He also served as the American Medical Association 1993 representative to the National Health Care Anti-Fraud Association.

Dr. Federgreen is involved on a national, regional and local level with auditing, review and due process of providers.

## Patricia J. Byrns, MD

Patricia J. Byrns, MD, is an Assistant Professor, Medicine and Preventive Medicine and Biometrics, at the University of Colorado School of Medicine. She currently serves as Chair of the CMS Data and Quality Committee and is a member of the Health Affairs Council. She is also a member of the Executive Board of the Colorado Society of Internal Medicine and has served on the Colorado Board of Pharmacy DUR Task Force.

In addition to her teaching, research and consulting experience, Dr. Byrns has published several articles and participated in both national and international conferences.

## Michael R. Vitek

Michael R. Vitek is the Director of the Department of Hospital Medical Staff Services at the American Medical Association (AMA).



The Department is responsible for providing staff support for the AMA's Hospital Medical Staff Section. Before joining the AMA, he was the Chief Executive Officer of a 129 bed hospital in Northern Arizona and a 52-bed hospital in Western Colorado. He was the first non-physician to serve as the President of the Colorado



# Speakers for Educational Program

## *From previous page...*

Board of medical Examiners and to be elected to the Federation of State Medical Boards' Board of Directors. Mr. Vitek received his undergraduate degree from Oregon State University and his Masters degree from the University of Colorado Health Sciences Center. He is a fellow in the American College of Healthcare Executives.

### **Robert N. Alsever, MD**



Robert N. Alsever, MD, is Vice President, Quality Management, Sisters of Charity Health Care Systems, in Pueblo, Colorado. He received his MD degree from the

University of Colorado School of Medicine and specialized in endocrinology and metabolism. He served as staff physician in the Southern Colorado Clinic until 1991 and has served in administrative medical positions since then.

Dr. Alsever has published more than 25 articles/books, implemented numerous Medical Information Systems at St. Mary Corwin Hospital, and presented at more than 45 local to international conferences. Dr. Alsever is currently a member of the CMS Data Committee.

### **Val C. Dean, MD**

Val C. Dean, MD, joined Compregare in 1989 and became the Senior Medical Director for TakeCare of Colorado in the merger of Compregare and TakeCare in 1993. He



is responsible for health services management, including utilization control, quality improvement, and health promotion. Dr. Dean received his doctorate of medicine degree from the University of Rochester School of Medicine and his undergraduate degree from Yale University. Recently he was appointed as a member of the NCQA Pilot Report Card National Steering Committee, and he participates on other national GHAA committees. He completed a family medicine residency at the University of Colorado and is a member of the American and Colorado Academies of Family Practice and the Colorado Medical Society. He had a private practice in family medicine for 15 years in the Denver community before going full-time with TakeCare.

### **Bonnie B. McCafferty, MD, MSPH**

Bonnie McCafferty served as Physician Advisor then as Associate Medical Director and Clinical Coordinator for the Colorado Foundation for Medical Care. She has been active in the areas of data research and analysis and quality improvement and utilization review activities. She is an active member of the CMS Data Committee. In addition to two years of intensive care nursing, Dr. McCafferty has been involved in direct patient care ranging from urgent care medicine in a walk-in clinic to primary care in a group practice setting. She received her medical degree from the University of North Carolina School of Medicine and completed her Mas-

ters' Program in Public Health at the University of Colorado Health Sciences Center.

### **Marie G. Kuffner, MD**



Marie G. Kuffner, MD, is a practicing anesthesiologist, Chief of Staff and an associate professor of anesthesia at the University of

California Los Angeles (UCLA). She is a diplomate of the American Board of Anesthesiology.

Dr. Kuffner has served in numerous capacities as a hospital medical staff leader, including as a member of the medical staff executive committee, secretary of the medical staff, chair of the medical staff/hospital administration liaison committee, and as a member of the credentials committee. She also serves on the editorial board of the "UCLA Medical Staff Forum," and on the UCLA Medical Faculty board.

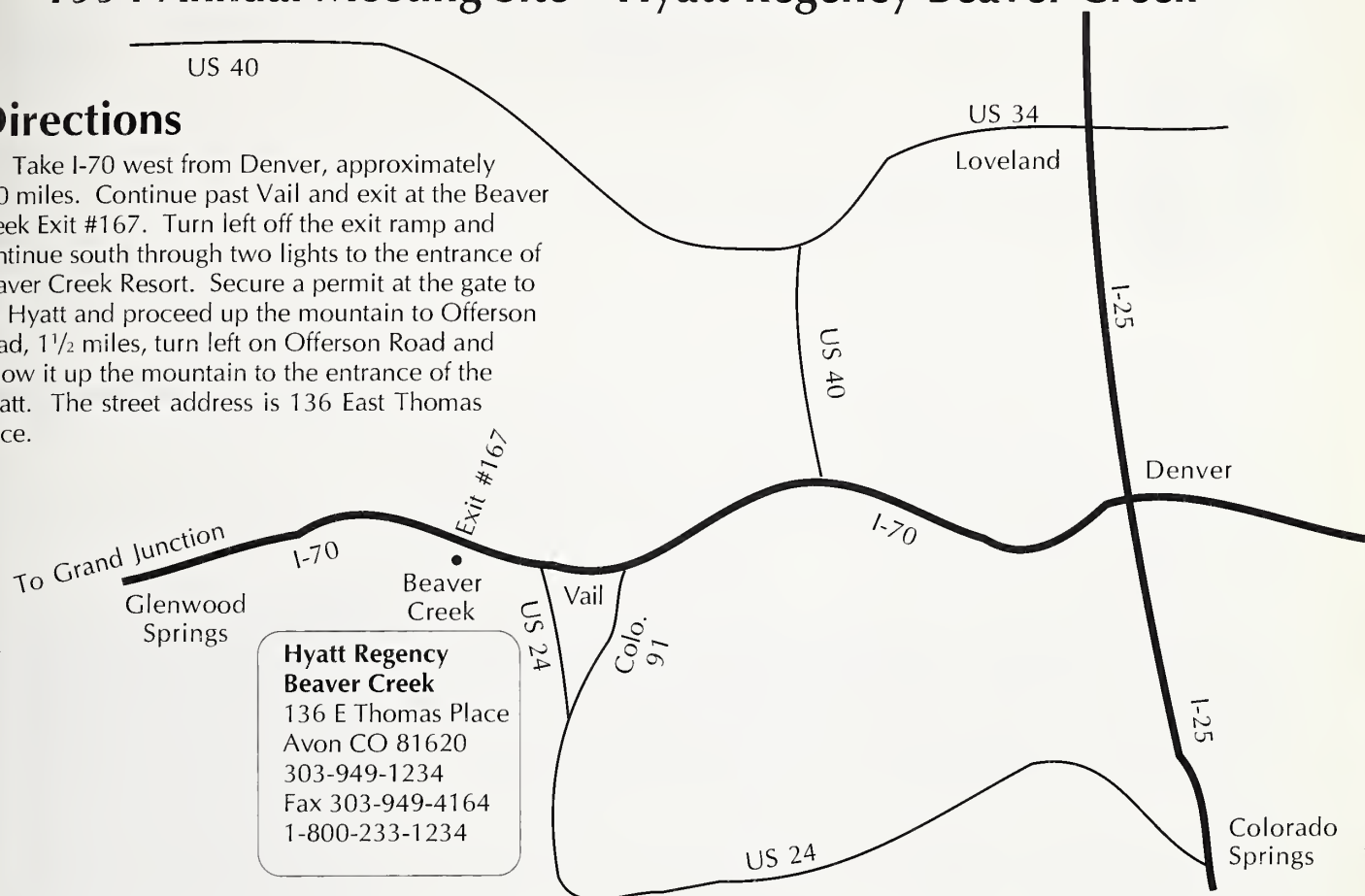
Her activities in organized medicine include her position as the American Medical Association Hospital Medical Staff Section (AMA-HMSS) delegate to the AMA House of Delegates. From 1983 to the present she has served as a member of the AMA-HMSS Governing Council.

Dr. Kuffner is on the Board of Trustees of the California Medical Association (CMA), chaired the CMA-HMSS from 1989 to 1991, and is chair of the CMA Council on Medical Services. She is past president of the Los Angeles County Medical Association (LACMA) and was on the LACMA Board of Trustees from 1986 to 1989.

# 1994 Annual Meeting Site—Hyatt Regency Beaver Creek

## Directions

Take I-70 west from Denver, approximately 110 miles. Continue past Vail and exit at the Beaver Creek Exit #167. Turn left off the exit ramp and continue south through two lights to the entrance of Beaver Creek Resort. Secure a permit at the gate to the Hyatt and proceed up the mountain to Offerson Road, 1½ miles, turn left on Offerson Road and follow it up the mountain to the entrance of the Hyatt. The street address is 136 East Thomas Place.



## Hyatt Regency Beaver Creek Welcomes

Name \_\_\_\_\_

Name(s) of additional person(s) sharing room: \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Arrival date \_\_\_\_\_ Departure Date \_\_\_\_\_

### Please reserve the following:

Single \_\_\_\_\_ Double \_\_\_\_\_ Request King bed \_\_\_\_\_ Request two double beds \_\_\_\_\_

Note: To assure your reservation, please enclose your deposit or supply credit card information which will be charged for the deposit. Reservations received without a deposit will be returned. Based on availability, the above rates will be honored three days prior to main group arrival and three days after main group departure.

Circle name of card: American Express Visa MasterCard Diners Club Carte Blanche

Please use only one card per room  
 Credit Card# \_\_\_\_\_  
 Name on Card \_\_\_\_\_ Expiration Date \_\_\_\_\_

Reservation Deadline: August 14, 1994

Reservations accepted after this date are based upon availability.

Comments:

**Meeting Dates**  
**Sept. 8-11, 1994**

Single Rate ..... \$115 + tax  
 Double Rate ... \$115 + tax  
 Triple Rate ..... \$130 + tax  
 Quad Rate ..... \$130 + tax  
 Current tax rate is 9.2%

**Deposit**



## CMS Annual Meeting Golf Tournament

at Beaver Creek Golf Club  
Thursday, September 8, 1994  
Entry Form

Name \_\_\_\_\_

Address \_\_\_\_\_

*Please give us the following information for tee times and emergencies*

Office Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ FAX# \_\_\_\_\_

(Needed for tee times)

While at Beaver Creek I will be staying at \_\_\_\_\_

I will be attending the meeting in the capacity of (check one)

☐ Physician

☐ Exhibitor

☐ Spouse

☐ Other

I will:

☐ Sponsor a golf course hole @\$100

☐ Sponsor a putting green contest hole @\$50

Name of sponsor (as you wish it to appear on sign) \_\_\_\_\_

*(Professionally made signs will be displayed for sponsors. All proceeds will directly benefit the CMS Medical Indigence Program)*

My golf handicap is \_\_\_\_\_

☐ USGA

☐ Other

I will require rental clubs @ \$24 \_\_\_\_\_

☐ Left handed

☐ Right handed

Play will be scramble format. Foursomes will be arranged according to various levels of ability by the golf professional. If you have a preference of who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament entry, registration form and advance payment of \$100 must be received **no later than** August 16, 1994. Cancellations received after August 28, 1994 are refundable subject to ability of Beaver Creek Golf Club to "resell" vacated tee times.

You will be notified regarding tee times. A shotgun start will not be possible, therefore, please be prompt with your tee times. To reserve other personal tee times, please call the Pro Shop at 303-949-7123.

I prefer to be teamed with \_\_\_\_\_

Mail Entry Form and check to Media Specialties, P. O. Box 36357, Denver, CO 80236. For additional information, call Tim Jackson at 303-986-5926.

## Baby-sitting Available

Call the concierge at the Hyatt Regency to arrange for your child care needs during the CMS Annual Meeting, (303) 949-1234 or 1-800-233-1234.



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## Activities for the Whole Family

There are many things to do at Beaver Creek, from Jeep tours and whitewater rafting to hot air balloons, chairlift rides and picnic hikes. For a listing refer to the June, 1994 issue of *Colorado Medicine* or call concierge at the

**Hyatt Regency Beaver Creek**

136 East Thomas Place  
Avon Colorado 81620

(303) 949-1234

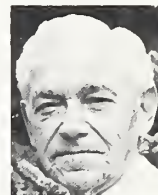
FAX (303) 949-4164

1-800-233-1234



## THE LOBBY

by Frederick A. Lewis, Jr., MD  
Chairman  
CMS Council on Legislation



In this space in the month of June\* I presented a resolution concerning Family Practice. The resolution was passed by the 1994 Colorado General Assembly during its final days. I made some personal comments about the resolution and invited feedback. Over the past month I have received these replies, both pro and con. I would like to thank all of the physicians who responded and hope that they do not mind if their remarks are made public. In my opinion, it is healthy to have an open expression of opinion on controversial topics and I would hope that anyone else who has an opinion would let it be known.

\* Dr. Lewis is referring to a recap of the 1994 legislature he wrote for the "120 Day Newsletter" which was published at the close of the General Assembly short session (120 days).

Dear Fred:

Regarding your request for feedback on your June 1, 1994 "Looking Back": Bravo! You have said so well what I have frequently tried to say but only better! Hopefully you will not antagonize the family physicians who, yes indeed, have been under-appreciated and underpaid for many years. But that certainly does not justify the current groundswell of statements regarding a disproportionate under-representation of family physicians in our medical community. I will enclose a copy of a letter only today mailed to the *New England Journal of Medicine* responding to some editorial pieces that deal with this issue. Of course, in this letter I have been more parochial to my subspecialty, but actually that's part of my job, isn't it?

Again, congratulations on the extremely well presented statement dealing with a difficult issue.

Sincerely,  
Herbert Kaplan, M.D.

Dear Dr. Lewis:

In response to your note in June 1, 1994, newsletter, I write:

Being a family physician may discount my response, but it is nonetheless my perspective. I understand the Colorado Medical Society is charged with the difficult task of representing its constituents, namely physicians in all specialties.

I believe that some of the paralysis in the political structure emanates from the inertia of an institution. Lobbyists and other representatives of the status quo fight

change.

Managed care has arrived because the needs of society have not been met (primarily on the economic front) by the "old medical system", mainly indemnity care. The Colorado Medical Society and medicine in the state of Colorado can be a barrier and fight these changes, or participate and help influence the changes. There are many studies which show not only the less expensive care given by family physicians, but more cost-effective care as well.

It would be my hope that the Colorado Medical Society would take a leadership role in steering the cart of medical change. Opposing legislation such as HB 1186 takes some of the air out of its tires, in my opinion. In your third paragraph, you report this bill was opposed by the CMS primarily because you felt it would tend to fragment medicine. I would argue you are fragmenting the Colorado Medical Society into primary care and specialty care pieces by opposing this bill.

Sincerely,  
Matt McCoy, M.D.

Dear Dr. Lewis:

I am responding to your request for comment on the resolution regarding family practice just passed by the legislature (CMS Newsletter of June 1, 1994).

My reaction is in complete agreement with yours. I agree with the final resolve but feel the "Whereas" language is unsubstantiated, divisive and contentious.

My specialties are pathology and





## THE LOBBY

### LETTERS

genetics. I am supportive of the need to bolster our colleagues in family medicine in terms of prestige and compensation. I hope and believe this can be achieved within a framework that preserves the collegiality of all physicians working as a group to ensure quality patient care, retention of effective physician input in the delivery of medical care, cost effectiveness of that delivery, and fairness to patients and all physician groups. Fragmentation of our ranks is bad enough already and is a danger that must be guarded against.

You ask for readers' opinion on the concept of a statewide physician-controlled managed care organization. My opinion is influenced by my firm belief that the greatest danger we face (both as patients and doctors) is control by the insurance bureaucracy. Already this monster drains off a significant portion of the nation's health care dollars, and seeks not only to further increase their financial parasitism, but also to completely eliminate the physician from his/her role as patient advocate in health matters.

After many years of opposition, I now support the single-payer concept for health care funding, believing this is the only effective way to eliminate the greater evil of insurance bureaucracy. If the physician-controlled "HMO" can be a step in this direction I would be glad to support the idea.

Sincerely,  
W. R. Adams, M.D.

Dear Dr. Lewis:

Your presentation of the "Whereas" Resolution was important and also fairly done. Furthermore, the comments you make are correct and clearly presented. I agree with your analysis.

It has been my experience that while some family physicians are really very good in recognizing problems and seeking specific questions, either by telephone consultations or referral, others are woefully slow in eliminating confusion in diagnoses. Particularly interpretation of laboratory data seems to be below optimal standards in many cases.

One might ask "To whom does the family physician refer his family members?" and "How promptly does that occur?" An additional thought is that frequently the reduction of duration of illness for the patient may be reduced by seeking expert advice sooner rather than later. This is also part of the continuing medical education for which credits are not offered and probably are equally as valuable as television programs and drug company sponsored print quizzes.

Your effort to continue to educate legislators should be rewarded. I am hopeful that some of this information will be useful to you.

Sincerely,  
Merritt C. Rudolph, M.D., M.A.C.P.

Dear Fred:

I am writing in response to your request for feedback on the legislative resolution regarding family medicine. You stated that you had no problem with the "resolved", but it was the "Whereas" clauses that bothered you. I would submit that there is only one "whereas" that is a problem, and that is the first one. It states: "WHEREAS, Family physicians are **the** (emphasis added) key to better, more efficient, and less costly health care;..." It's the word "the" that's the problem here. If the resolution said "a", we would probably not find it as troublesome. The rest of the "whereas" clauses are supportable — family physicians do provide care to all segments of the population, they respond to 80-95% of the problems that come into their offices, most rural physicians are family physicians, health care reform proposals call for more family physicians (and other generalists), and there is a Commission on Family Medicine in this state with the charge mentioned in the last "Whereas".

The origin of the resolution is clear — it came from the family medicine lobby. The use of the word "the", in my opinion, is also understandable. (Most human behavior is understandable if we have enough history). For several decades, family medicine has been relegated to the lower end of medicine's totem pole. This is true whether one looks within Schools of Medicine, organized medicine, or most obviously, if one looks at how reimbursement dollars

(Continued on following page)



## LETTERS

have flowed for the last generation. In 1994, there are significant changes occurring in medicine. Our School, and many others, are recognizing that we need to do more to train more family physicians, as well as general internists and pediatricians. We are changing curricula, in both undergraduate and graduate medical education, and our clinical practice organizations to be more inclusive.

The most telling change is in the marketplace. The President of the Institute of Medicine was in town the other day and told us that in San Diego, practice groups were hiring cardiologists out of training at \$77,000, and family physicians out of training at \$120,000. Similar things are happening here. Another indicator is that our school has requests from at least four health systems or hospitals to help them begin family medicine residencies.

From my perspective, it is imperative that all of us in medicine begin to work together to assure that the transition from what was to what will be goes well so that all of us adapt to this change in a way that preserves our basic values. We need to acknowledge that we have mistreated our family medicine colleagues in the past, and ask that they now use their newfound prominence wisely. If we don't, and we keep ourselves occupied with intra-squad squabbling, there are plenty of other health professionals in nursing and the allied health professions who will be happy to step in and fill the void.

Sincerely,  
Richard Krugman, M.D.  
Dean, School of Medicine

Dear Dr. Lewis:

I have read with some concern the first page of the Colorado Medical Society newsletter. I am an orthopedic surgeon practicing in Fremont County. I would also take issue with some of the "Whereas" statements made by the family physicians. Orthopedic surgeons in general would take exception to the fact that our care of musculoskeletal problems is less efficient and more expensive than that of primary care providers. We feel that we are the best trained to be primary care providers for injuries of the musculoskeletal system and that we handle them economically, efficiently, and with the greatest expertise. We in Fremont County are quite conscious of over-utilization issues and generally manage patients conservatively and on self-directed exercise programs whenever possible. We also provide health care to all segments of the population from Infants to the very elderly. In Fremont County, by my rough count, we have 24 physicians, nine of whom are family practitioners. Specialists represented include orthopaedic surgery, urology, ophthalmology, pediatrics, obstetrics and gynecology, internal medicine, anesthesiology, pathology and radiology. There are fifteen specialists in Fremont County, so family physicians are not in the majority in this rural area. I believe that there is no question that improvements in specialty care and preventive medicine have been great contributors to the high standard of healthcare in this country. Healthcare reform appears to be placing specialists and primary care providers at

odds with each other. Cooperation between primary care providers and specialists in Fremont County has been exceptional during my tenure here and we all hope that it will continue. Maintaining access to specialty care and allowing the patient to choose his or her physician are key to providing healthcare without sacrificing quality. We all appreciate your work on our behalf.

Best regards,  
Jacob F. Patterson, M. D

***And then . . .***

***there were***

***letters to the Editor . . . .***





## LETTERS TO THE EDITOR

To: The Editor, *Colorado Medicine*

In the April and May issues of *Colorado Medicine* and the June 120 *Day Newsletter*, Dr. Fred Lewis, Jr., writing as Chair of the Legislative Committee of the Colorado Medical Society (CMS) took issue with several causes championed by the Colorado Academy of Family Physicians (CAFP) and the Commission on Family Medicine (COFM). There are several concerns related to these articles; some are issues of inaccuracy, others are issues of perception and respect. I would like to highlight for you some of the issues I think are important that are raised by Dr. Lewis' remarks.

1. "Fragmentation within the ranks of organized medicine." I agree with Dr. Lewis that this has occurred, particularly in the last few years. The trend is likely to continue in view of some of the statements included in this article. It has been the opinion of a majority of the members of the Board of Directors of the CAFP that the CMS does not represent the interests of Family Physicians. Thus, the CAFP has pursued a course of legislative effort and lobbying which we have believed to be responsive to the needs of Family Physicians and families in the state of Colorado. We have believed that we have been following the directives and desires of CAFP members in that regard.

2. The definition of primary care put forth in Representative Prinster's bill (HB1186) was not sponsored by the CAFP. We did, however, try to keep the definition focused on continuous, comprehensive care of patients. The definition of primary care physician in Representative Prinster's bill included

Family Physicians, General Internists, General Pediatricians, and Ob-Gyns. Dr. Lewis would have you believe that "probably 50 % of primary care rendered by physicians in this state is provided by specialists." I suggest that just because a cardiologist treats a patient's sinusitis does not make him or her a primary care physician. We did not try to limit the definition to "all physicians who do not have a three year residency in family medicine" The position of the CMS was that ALL physicians do some primary care in their practices and thus the definition should be based upon the type of service rendered and not the training, breadth of practice, or specialty designation of the physician. It is true that we and the CMS were at odds on this issue. I think the reasons are obvious.

3. The legislative resolution referred to in Dr. Lewis' article was introduced by the Commission on Family Medicine, not by the CAFP. The resolution simply provides a method whereby the Commission on Family Medicine will comply with the terms of their original charter, nothing more and nothing less. Note the sentence which reads "Whereas the Commission on Family Medicine, in section 25-1-903, Colorado Revised Statutes, is charged with identifying specific areas of the state that are underserved by family physicians and determining the priority of needs among such areas..."

4. I am very troubled by Dr. Lewis' comment "...I do not feel that these past societal errors justify an attempt on the part of primary care physicians to restructure the practice of medicine in a manner that will allow them to retaliate against the rest of medicine at the expense or the welfare of patients." We

believe that having a primary care physician leads to increased quality, decreased cost, and increased patient satisfaction. This statement is offensive to our specialty and to the intelligence of our patients.

5. The final statement that I want to comment on is "Family physicians probably can offer less expensive care to more people WITH SOME CORRESPONDING SACRIFICE IN QUALITY OF CARE IN KEY AREAS. (Less expensive is not the same thing as cost effective.)" This appalling statement requires response. In the first place it is not supported by studies done by the Rand Corporation which clearly documented a more cost effective practice on the part of Family Physicians, with the same outcomes as the practice of limited specialists. The article in *JAMA* 1992;267:1624-1630 found consistently higher utilization of resources by subspecialists without any change in outcome. In the second place this statement indicates a lack of respect for the skills, education, training, and expertise of Family Physicians.

The reason the legislature and the CAFP promote ideas like the ones which Dr. Lewis, Jr. finds so offensive is because there are too many specialists (see *NEJM* Jan. 14, 1993 "The Marketplace in Health Care Reform") and we need to find a way to get more primary care physicians for the citizens of Colorado. (The marketplace will indeed define who is delivering primary care and who is not, just ask any HMO exec.)

Representatives from the CAFP Board of Directors, Nancy Ashbach, MD, President, Dick Nicholas, MD, President-Elect, Tim Dudley, MD, Legislative Chair, Ken Olds, MD, Delegate

## LETTERS TO THE EDITOR



and Randi Morris, Executive Vice President met with Colorado Medical Society President Bill Bailey, MD, President-Elect David Martz, MD, and Sandy Maloney, Executive Director, on Wednesday June 29 to discuss the allegations found in Dr. Lewis' articles. The official CMS stance is that it is not represented by what the article said, that the article was highly inflammatory but that there is confusion among specialists of the role of generalists. The official CMS stance is that they want to work with the CAFP to keep educating members and find common ground on which we can work together. The CAFP strongly agrees we need to figure out a way to work together. As we prepare for the 1995 legislative session let us look for areas where we can speak with a unified voice but respect legitimate differences of opinion where they occur.

Nancy W. Ashbach, MD  
President, CAFP

Dear Editor:

The lead article in the June 1, 1994 issue of the **120 Day Newsletter** from the Colorado Medical Society (CMS) presented and commented on a Senate joint resolution passed at the 1994 Legislative Session in support of the work carried out by the Colorado Commission on Family Medicine (COFM). Dr. Frederick Lewis, writing as Chair of CMS's Council on Legislation, interpreted the document as "deeply symbolic of the chasms which currently split medicine", suspected that the Colorado Academy of Family Physicians (CAFP) "had a hand in drafting" the resolution, and noted that the "WHEREAS" clauses could not be

objectively substantiated. Dr. Lewis summarized his objections to the "WHEREAS" section with a statement that is sure to further the "fragmentation within the ranks of organized medicine" rather than foster a spirit of collegiality and cooperation: "Family Physicians probably can offer less expensive care to more people with some corresponding sacrifice in quality of care in key areas. (Less expensive is not the same thing as cost effective.)"

This remark and other similar statements voice disrespect for the practice and profession of Family Medicine. Dr. Lewis' inaccurate information, misunderstanding of CAFP's legislative intent and activities, and his disregard for recent work force and cost-effectiveness studies in health care lend further strength to building an atmosphere rife with suspicion and mistrust. COFM presumes that the opinions presented in Dr. Lewis' article are not widely shared by the CMS general membership. With this expectation in mind, this COFM response to Dr. Lewis focuses on clarifying the origin and intent of Senate Joint Resolution 94-31, rather than on presenting a point by point rebuttal of his remarks. We hope that highlighting the purpose of COFM and presenting the background to the drafting of the resolution will contribute to creating an environment in which CMS and the various specialty organizations in Colorado can both work and speak together, as well as mutually agree to respectfully "disagree" when opinions and perspectives may rightfully vary. The welfare and care of patients, we think, form the keystone to balancing collaboration with respectful disagreement.

The State Legislature established

COFM in 1977 (Sections 25-1-901 through 25-1-904 of the Colorado Revised Statutes). Through the formation of this Commission, the Legislature mandated that all of the State's Family Medicine Residency Programs work together with the citizens of the State to address both Family Medicine training issues and the State's health care needs. The Commission consists of citizen representatives from each of the State's six congressional districts, the Director of each of the Family Medicine Residency Programs in Colorado, the Dean of the University of Colorado School of Medicine and a representative of CAFP.

The work of this consortium, which includes allocating State funding for Family Practice Graduate Medical Education, has been a key contributor in building a strong contingent of ten Family Practice Residency Programs with an enrollment of 216 residents for the 1994-95 academic year. Colorado Springs, Ft. Collins, Grand Junction, Greeley and Pueblo each are home to one of the Residency Programs. The other five programs are based in metropolitan Denver and participate in the Commission's requirement that each resident spend at least one month training in a rural or urban underserved area, in an effort to help meet the needs of these locales. Historically, about 85% of the residents recruited for these programs have come from out-of-state and the greater majority of these graduates take up practice in Colorado. COFM traditionally has played an important role in recruitment and retention initiatives.

The Commission is charged with making recommendations to the General Assembly concerning appropriat





## LETTERS TO THE EDITOR

ing funds for the Family Practice Residency Programs and identifying specific areas of the State that are underserved by Family Physicians (Section 25-1-903). In this context, we were asked: "How many Family Physicians does Colorado need?" Although no Senate joint resolution was needed to both comply with our mandate and respond to this direct question, COFM had a twofold strategy in requesting that this resolution be introduced to the General Assembly. First the Commission believed that a resolution would give some impetus to preparing a meaningful needs assessment. Secondly, such a document could serve as a tool for enlisting the cooperation and collaboration of other entities with an interest in knowing more about Colorado's need for Family Physicians, e.g. the Health Professions Panel of the Colorado Trust, the School of Medicine, CAFP, the Department of Family Medicine, the Colorado Society of Osteopathic Medicine, and the Colorado Department of Health. Coordination of efforts can go a long way in addressing some of the acknowledged shortcomings of previous surveys, produce a study with diversified acceptability and use, and, finally more effectively benefit the citizens of our State, especially those with limited or no reasonable access to primary care.

The Commission also has a vested interest in seeing that a sound assessment of Colorado's need for Family Physicians is carried out. This concern, as rooted in COFM's legislative charge, centers on identifying the fiscal resources needed to support the current level of Graduate Medical Education in Family Medicine and on determining need and capacity for growth. State

monies allocated through the Commission will be severely stretched when the new Family Practice Residency at Swedish and the University-based Family Practice Residency at Rose qualify for these funds.

Senate Joint Resolution 34-91 is not an isolationist document nor is it intended to be egocentric. We firmly believe that the diverse forces creating our contemporary health care marketplace will not tolerate self-centered, self-serving efforts. As representatives of Family Medicine, we are profoundly aware of the prominent position Family Physicians now share with other colleagues. Likewise, we are acutely conscious of the corresponding responsibilities associated with sharing in the leadership engaged in the transformation of our local and national health care system. We envision progressive change within a setting that serves citizens and patients with accessible, affordable and effective health care, while upholding the integrity and merits of the diverse medical profession.

Sincerely,

Jan Kochis, BS, RD, Char  
Austin Bailey, MD, Vice Chair

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# Vaccines For Children

## A New Federally-Funded Vaccine Program To Increase Children's Access

Earlier this year, the CMS COUNCIL ON HEALTH AFFAIRS agreed to pursue two public health projects. Areas chosen for project development were rural health and the health of Colorado's youth. Subsequently, a Task Force was convened in each of the these areas.

THE TASK FORCE ON YOUTH, as one of its first actions, voted to support a new federally-funded, state operated program called Vaccines For Children (VFC) which will increase children's access to immunizations. The Task Force determined that such support would consist of 1) providing information to the CMS membership about the VFC program and 2) submitting a resolution to the House of Delegates which recommends that CMS encourage its members to participate in the VFC program. Members of the Task Force on Youth noted that while the VFC program will generally increase children's access to immunizations, those who are underinsured be required to receive their vaccinations at federally qualified health centers (see section on Eligibility).

The following article is intended to accomplish the Task Force's first goal.

On October 1, 1994, the new Vaccines for Children program (VFC) will begin providing federally-purchased vaccine at no cost to all public health care providers and to

private providers who agree to participate. Approximately 60% of U.S. children are expected to be eligible for the VFC program.

The program will enable private health care providers to offer parents \$270 of free vaccine for each eligible child in their care. VFC will additionally allow many children to receive comprehensive health care from their private providers by reducing or eliminating the need to refer children to public clinics for vaccinations.

### Eligibility

The program was created to meet the immunization needs of children birth to 18 years of age. Children eligible to receive VFC-provided vaccines include: 1) children enrolled in Medicaid; 2) children who do not have health insurance; and 3) children who are American Indian or Alaskan Native.

Children who are underinsured will also be eligible for the VFC-provided vaccines. However, the program stipulates that underinsured children must receive their immunizations at federally qualified health centers or rural health clinics.

### Private Provider Participation

Since over half of all children in the United States receive their immunizations from the private



Robert D. McCartney, MD  
Chair, Health Affairs Committee



*from previous page...*

*A monthly report of current and ongoing activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.*

medical community, the support of private providers for the program is essential. To that end, the designers of the VFC program endeavored to create a simple, streamlined provider enrollment process. Providers are asked to:

- Screen their patients for eligibility - (verification is not required)
- Maintain a record of this screening for those that receive VFC-provided vaccines
- Follow the recommended immunization schedule as established by the Advisory Committee on Immunization Practices and state law
- Not charge for VFC-provided vaccines. An administration fee may be charged. (Regional fee caps will be set for administration fees by the Health Care Financing Administration.) No child who is VFC eligible may be denied vaccination because they cannot pay the administration fee. An office visit fee may also be charged.
- Provide vaccine information materials and maintain records as required by law
- Complete 2 one-page forms - a provider enrollment form and a provider profile, which is used to order the vaccine.

Private health care providers who participate in the program will not be required to accept new patients merely because they are eligible to receive vaccines through the VFC program. Also, physicians may participate in the program without being enrolled as state Medicaid providers.

## Vaccines Currently Available Through VFC

At present, the vaccines which are available through the VFC program are as follows:

diphtheria  
*Haemophilus influenzae* type b  
 hepatitis B  
 measles, mumps, rubella  
 pertussis  
 poliomyelitis  
 tetanus

Providers will be supplied with new vaccine combinations as they are approved by the FDA and recommended by the Advisory Committee on Immunization Practices (ACIP).

## How To Enroll

The Colorado Department of Health has sent enrollment packets to approximately 3,000 physicians in the state. Those packets should arrive at physicians' offices by mid August. If you have not received a packet by mid August and wish to enroll in the Vaccines For Children program, contact Jackie Murray at the Health Department at (303) 692-2798.



*The following has been abstracted from the Colorado Foundation for Medical Care's (CFMC) quarterly newsletter reporting on current projects of the Foundation. For more information, or if you would like to participate in a study group, call 303/695-3300, ext. 3065.*

Under the Fourth Scope of Work for Medicare, CFMC staff work with providers to develop projects that address important issues for the state's Medicare population. The merits of the projects selected are assessed individually and in comparison with one another, projects are approved or denied, and approved projects are prioritized.

• **Medication errors:** The Study Group met the beginning of June to discuss the findings following data collection at six hospitals. The hospitals involved in the pilot study are interested in proceeding with the project after refinement of the data collection instrument.

• **Back & neck procedures:** The Study Group has requested that this project move into the feedback stage. We are in the process of refining the presentation and scheduling meetings to provide feedback.

• **Prostatectomy trends:** A Study Group meeting is being scheduled for early July to review the results and formalize recommendations for urologists. Follow-up of abnormal test results: Review of the data has revealed minimal problems in identification of abnormal tests/not addressed. Hospitals involved in internal investigation of their process do feel, however, that abnormal tests not addressed, is a substantial problem. The feasibility of conducting this study continues to be explored.

• **Carotid endarterectomy:** This project will be a collaborative effort among five PRO's from geographically diverse areas. A CFMC staff member has attended the abstractor

training session in Atlanta, Georgia to learn to use the data collection software developed for use in this study.

• **Transfusions in elective surgery:** We are collaborating with several other states on this project. Three procedures have been identified for inclusion in the project: total hip replacement, total knee replacement, and hysterectomies. The focus of this project is to evaluate the appropriateness of blood transfusions given and the use of autologous blood for these three procedures.

• **Aspirin use in Ischemic heart disease:** We have initiated a collaboration with several hospitals. A data collection tool is close to completion and the abstraction of records is targeted to begin in late July.

• **ACE Inhibitor use in diabetes:** Information has been obtained that suggests consensus among Endocrinologists and Internal Medicine Physicians regarding the use of ACE inhibitors in diabetics. The team is working to identify the population for study.

• **Aspirin/Thrombolytics in AMI - Mountain States Research Network:** This project is a collaborative effort involving nine PROs in twelve states. The purpose of the project is to study the timely and appropriate use of aspirin and thrombolytics in AMI patients. A collaboration has been established with eight Colorado facilities. The first study group is planned for July 14th.

• **Stroke/TIA:** We are taking part in a study that is being coordinated by DuPont Pharmaceuticals. The project will focus on the use of coumadin in a trial fibrillation, possibly leading to

the prevention of stroke/TIA. We are in the process of compiling data that will be forwarded to DuPont for use in the project.

• **HMO documentation study for blood pressure:** This project was approved by the Steering Committee. A data abstraction tool has been completed to include all cases for HMO review for the final quarter of 1994.

• **ACE Inhibitor use and angioedema:** The team has been assigned and will meet June 22nd.

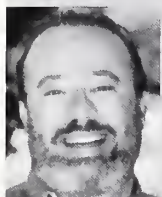
• **Transfusions in chronic anemia:** The Steering Committee approved this for a project and a team has been formed.

• **Ischemic heart disease module development:** The following quality indicator has been selected by the expert clinical panel for development: "Patients with a working and final diagnosis of Unstable Angina should have an EKG completed within 20 minutes of arrival at the medical facility. At the present time, chart data collection has begun. We anticipate initial feedback to the collaborating hospitals in August. (See "In Depth: Ischemic Heart Disease Module Development.")"

• **Stroke/TIA module development:** The expert panel has selected the following indicator for development: "TIA/Ischemic Stroke patients that do not have an allergy, intolerance, or contraindication to aspirin, warfarin, or Ticlopidine should be discharged on aspirin, warfarin, or Ticlopidine therapy. The initial chart abstraction has begun."



## Book Review



1994 by Ken Propper

Robert J. Pensack, MD  
Steamboat Springs, Colo.

Steamboat Springs Psychiatrist Robert Pensack, MD has opened the lid of his soul and let us all have a good, long look inside. And when we look away, we find that we cannot look at anything else in quite the same way anymore. The sheer, incredible depth of his honesty gives the reader the closest thing to actually understanding what it feels like to battle against an inexorable disease for thirty years and come out on top.

Bob Pensack may not like that characterization that he has come out on top. One gets the impression that he is still pushing against the odds, but the fact remains that in his life and death struggle, life has won out, at least for the time being. And yet, Dr. Pensack manages to completely avoid grandstanding, morbid introspection or any hint that he thinks of himself as anything other than a very ordinary person who has had extraordinary experiences.

All this happens in *Raising Lazarus*, a book to be published in September by G. P. Putnam's Sons in New York (304 pages, \$22.95), which is coauthored by Dr. Pensack and Steamboat Springs author Dwight Williams. This is one of those rare nonfiction books you will find as riveting as any novel. You find yourself really identifying with Dr. Pensack's struggles and triumphs in a very personal way, even though his life may be very different from your own.

The book traces the path of Bob Pensack from vivid childhood memories of his mother's death through shared experiences with his brother and his own constant battle against the disease they all share, Hypertrophic Cardiomyopathy (then called Ideopathic Hypertrophic Subaortic Stenosis). It is a journey of the mind, of the spirit, of the emo-

tions. It is a story of the fragility of human life and sanity, told with such clarity of detail that you can almost smell the rich humus under the colorful autumn sky in New England.

Transplantation pioneer Thomas Starzl, MD notes in the foreword that it "is also an epic of progress in the field of transplantation which dawned in 1962 at almost the same time that Bob Pensack's medical diagnosis was made, and reached full bloom in time to save him thirty years later." Dr. Starzl relates how Dr. Pensack helped them develop an antirejection drug in 1972 which later helped save his life. The two transplant surgeons who gave Bob Pensack new life trained in surgery while Dr. Starzl was their chief at the University of Colorado and this past January, when his new heart was being damaged by recurrent rejections, it was a call to Dr. Starzl, now in Pittsburgh, which gained him access to the latest experimental antirejection drug.

This book is remarkable in its ability to reveal the common pathos we share as humans and is thus of universal appeal. However, it is even more relevant to physicians, especially those who live in Colorado, where so much of its action unfolds. Read this first-person narrative and gain compassion, understanding and insight into the life of one of your colleagues and many of your patients.

Robert J. Pensack, MD is a member in good standing of Northwestern Colorado Medical Society in Steamboat Springs, where he lives with his wife Abbe, and their two children, Max and Miriam, ages five and three, respectively.

*Note: Dr. Pensack is scheduled to sign copies of the book at the Tattered Cover bookstore in Denver from 7:30-9:30 pm on Wednesday, October 12, 1994.*



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## RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor



Mildred E. Doster, MD

There just isn't enough time or, for that matter, space on this page, to do justice to what Dr. Mildred Doster\* has done for medicine and humanity. If you don't know her, you should.\*\*

Dr. Doster has been a practicing physician (and she allowed it was all right to speak of this in real-time terms) since 1934. She came to Denver to practice in 1938 and has been making a huge difference in health care ever since. Even though she has retired from active, full-time practice at least twice, Dr. Doster continues to make a difference through her volunteering, giving of herself and her professional skills. She is still something of a whirlwind if you look at her daily calendar.

I started this rumination because a couple of weeks back I was invited to attend a tea to be given by the Colorado Public Health Association, in which Dr. Doster has been very active over the years. The Health Education specialists wanted to give something back to her. We were a small group at the tea, because there just wouldn't have been room for the many friends and admirers of Dr. Doster who would have attended had they known.

Dr. Doster was Assistant Director of Health Services for the Denver Public Schools for many years. She was devoted to the children and the job. Typically, Dr. Doster has said to me that the school is the most logical place to teach about health care. She said "Children bring their problems along with them every day. It costs so much to educate them, and then if they're not in good physical and mental health, they can't learn." At

the gathering honoring her, Dr. Doster made another point, saying 'We need to do more in health education; that's what's needed in this so-called 'health care reform.' If we would do more in health education, the rest of the reform wouldn't be needed, and health education would cost a lot less money."

1989 CMS President Robert Hartley was another campaigner for health education, particularly prenatal, saying "Prenatal care can save us years of struggle and millions of dollars down the road."

I also remember in 1990 when CMS President John Farrington told Governor Roy Romer that **Colorado had no long term health care policy** (*Colorado Medicine*, Vol. 87, No. 7, 188-189). Dr. Farrington laid out an eight-step program for Colorado health policy reform, the first step being "**Public education which will help improve or change our lifestyles.**", and the second, "**Public awareness programs on prenatal care, immunization and well-baby services.**"

Farrington also said "Colorado's economic development is a waste of time and money if we don't have a healthy population".

I sincerely hope the Governor or some other high up official person reads this, to realize that the physicians of Colorado Medical Society have been busy and concerned with the ongoing reform of health systems for many years, even before it was politically correct.

And I hope there comes a realization that the doctors have a lot to offer any such reform.

\* Mildred E. Doster, MD, Obstetrics, chose to go by her maiden name because her husband, Dr. Robert W. Virtue, an Anesthesiologist, said it was the easiest way to know for whom the night calls were intended.

\*\* "**Mildred Doster**"

by James J Delaney, Jr., MD

*Colorado Medicine* Vol. 80, No. 7. 184-185)



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"Advocating excellence in the profession of medicine"

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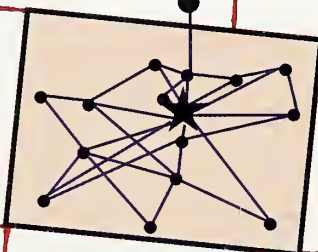
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Starting Shots: End of Year Thoughts .....by Wm. Carl Bailey, MD

Destination: Bangladesh .....p. 328

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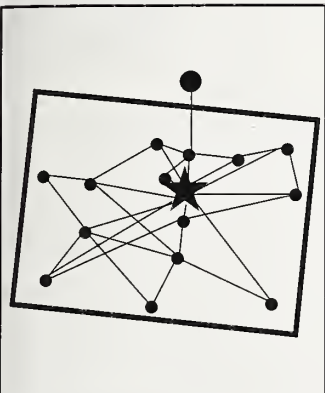
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# COLORADO MEDICINE

September, 1994

Volume 91, Number 9



## Cover Story

Your medical society will be moving toward a statewide network of physicians at the Annual Meeting this month. Will you be part of the problem or part of the solution?



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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Michael Thompson, Asst. Managing Editor; Gil Maestas II, Communications Specialist



Member, Colorado Press Association,



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Wm. Carl Bailey, MD  
President, 1993-1994

## "Parting Shots"

The 1994 Annual Meeting is rapidly approaching and this is my last opportunity to address you in these pages as your president.

The year has been eventful, and not without stress. If one were not humble at the beginning, the presidential year certainly offers opportunities to become so. I have learned a very great deal, for which I am indebted. It has been a distinct honor and privilege to serve in this office, and I wish to express my gratitude to all of you for that.

As I reflect on the challenges we have faced over this past year I have a little pride in some of the things accomplished, but also some wistfulness about the challenges not fully met and great concern about some new ones on the immediate horizon.

A member association exists for the purpose of gathering and disseminating information of value to its members, of educating its members, of doing things for them collectively which they can not do for themselves, and of advocating for them. A medical association undertakes these things also, but in addition takes on the responsibility of safeguarding the health of the community. In this regard, it is different from an ordinary member association. It is because of this ethical responsibility that physicians and their organizations are granted certain privileges not accorded other groups and professions.

We are rapidly losing some of these privileges. I have no doubt that it in part is because we are perceived to have abdicated our own self-imposed ethical responsibilities to

put the welfare of our patients ahead of our own. If we do not regain the moral high ground we have traditionally occupied, perhaps we deserve to lose our right to be a self-governed profession.

In addition, there is a general skepticism and iconoclasm abroad that questions and seeks to tear down all of our institutions — education, the church, government, business, law, the press, and certainly, medicine.

It is also true that there are a number of elements out there who want to bring the medical profession to heel for a variety of other reasons. Not the least of these is that doctors, while they account for only a relatively small percent of the health care dollar as professional income, control in large measure the way the health care dollar is spent. When considering that the health care industry now constitutes 15-17% of the GDP, or one trillion dollars, it is scarcely a surprise that commercial interests might want to wrest away control of this industry, to serve their own commercial benefit.

It is difficult for average physicians to accept that the reason health care is so expensive is because they are personally charging too much for their services, when they witness the incredibly high salaries of some of the new "captains" of this industry, and the very high "administrative" (non-value added) costs in the premium dollar paid by patients. It is particularly painful when the eleemosynary function of medicine, to take care of patients who are indigent, and to care for patients in government programs which are

*"The practice of medicine is a "local product". It is the quintessential intimate, personal service that one human being may provide for another."*



designed to provide less reimbursement than the cost of rendering the service, continue unabated. Neither does it make them feel any better when one of the most financially successful venture capitalists in health care today tells them baldly that while they are dithering about, thinking about "getting their act together", he intends to make a lot of money out of the vacuum that exists in physician and political leadership. All in the name of "efficiency" and lowered costs, of course. At the present time, the top ten most important issues in the competition for managed care contracts are "cost, cost.... and cost".

By the time it is recognized that quality has suffered terribly, the damage that will have been done to the infrastructure of the greatest medical system in the world's history may be nearly irretrievable. Meanwhile, having looted, the plunderers will have moved on to other more lucrative enterprise.

The medical society needs to do

its job better. We need to do a better job of discerning our members' needs, not just their wants. We need to do a better job of getting information back to them. We must do a better job of advocating for the profession. Above all, we must champion the needs of our patients. We are in a new epoch. It is time for new approaches, and a new kind of physician. We will have to learn to be comfortable in a corporate environment, in team efforts. We may even have to get used to the idea of taking care of populations of patients, and not just individual patients. I hope this does not mean that we have to practice mass-production medicine, that either we or our patients must become depersonalized, that we are reduced to a labor force, or a corps of bureaucrats.

The practice of medicine is a "local product". It is the quintessential intimate, personal service that one human being may provide for another. It requires compassion,

caring, and a personal relationship. The hubris that is exhibited by the politicians and the new class of merchant princes of health care, who would assume the role of brokers in the buying and selling of the services of physicians, does incalculable violence to that relationship.

It is high time that physicians took back their rightful role in the provision of health care. Physicians must band together to bring new efficiencies to the practice of medicine in the way which only they themselves can do. This can result in added quality and value for the patient, without destroying the humanism on which ethical practice is based.

It is my profound hope that the CMS House of Delegates will enthusiastically support the development of physician-owned and managed health care in the forthcoming Annual Meeting. It is essential for the future of health care in Colorado and this country.

# LEGAL UPDATE

*from Gelt, Fleishman & Sterling P.C.  
Denver, Colorado  
(303) 861-1000*

A financially successful business has many components. Accounts receivable are a wasting asset. The greater their "age" the less likely it is that they can be collected without dramatic discount. Some basic suggestions follow.

- Make sure patients sign fee agreements providing for interest on delinquent accounts and payment of collection costs. If all the patient's other creditors charge interest while you do not, your bill will go to the bottom of the pile. Describe the services and be explicit that the charges are the responsibility of the patient, not an insurance carrier.

- Set up — and follow — a collection procedure similar to:

Day 0 Billing Mailed

If Payment is not received by Day 30—

Day 31 Rebill with overdue notice and notice that "interest may be assessed"

Day 40 Call to inquire why payment not received

Day 60 First dunning letter indicating immediate payment required

Day 70 Second call to request payment/set up payment plan

Day 80 Second dunning letter advising that account will go to collection if payment not made in 10 days

Day 90 Turn over to collection agency if not paid

By the time an account is turned over to collection, a host of unpleasantness exists. The collection agency will take between 25% and 50% of any amounts collected, depending upon whether suit is filed. Generally, it is best not to get to this point. Patients who do not pay generally are chiselers, are upset with the medical care accorded and are ready to counterclaim for malpractice, or cannot afford to pay.

Providers are encouraged to contact their attorneys to prepare fee agreements and to create an effective accounts receivable/collection procedure flow chart and methodology. The reward from establishing a rational, coherent work processing system will repay itself multi-fold. For further information please contact:

A. Craig Fleishman, Managing Director  
Gelt, Fleishman & Sterling P.C.  
1600 Broadway, Suite 2600  
Denver, Colorado 80202  
(303) 861-1000

## EXECUTIVE DIRECTOR'S UPDATE



*Sandra L. Maloney  
Executive Director  
Colorado Medical Society*

This has been an exceptionally busy year for Colorado Medical Society.

CMS President Wm. Carl Bailey, MD, and I have traveled the state to visit various county societies. These trips are invaluable. We do not undertake these visits to just "spread the CMS word", but to learn from the membership. Dr. Bailey and I enjoy these informative visits. Shortly, Dr. Martz and I will schedule next year's visits.

I must state my sincere appreciation to all CMS staff for their tireless efforts over the past six months. They have adapted to the changes. Yes, there will be challenges ahead however, by facing these challenges together we can look forward to an exciting future here at the Colorado Medical Society.

As we look beyond the Annual Meeting to the year of change that lies ahead, I would hope all of medicine will realize that by acting in unison, we will succeed as the voice of patients and physicians. Yes, there is diversity of interests among Colorado physicians; however, we must join in common cause for the common good of your profession and your patients.

The activities of the Colorado Health Professionals Panel are still going strong. You will recall that the Colorado Trust has funded this project for the next three years. This group consists of about 32 community leaders who are looking at a myriad of issues related to medical education, funding of health care, scope of practice issues, access to health care, and the impact health

care reform will have on all these topics. I continue to chair a subcommittee which is dealing with the licensing and regulation of various Colorado health care professionals. In March 1994, the Panel made a presentation of our activities to key legislators and stakeholders. The Colorado Health Professionals Panel is now an official entity as articles of incorporation have been filed. I participated in the Search Committee process during which we hired Mr. Vic Harris to serve as Executive Director for the Panel. The subcommittees are meeting on a regular basis and the full Panel will probably convene sometime in October.

I remain a member of the Colorado Personalized Education Program for Physicians (CPEP) Board of Directors. Currently, I serve on the Personnel/Finance Committee as well.

CPEP, under the leadership of John Mueller, MD, President and Beth Korinek, Executive Director, is doing well.

The Denver Business Journal has recently notified me that, for the third year in a row, I have been named to their list of "Who's Who in Health Care".

This past year Dr. Bill Bailey undertook the challenge of change and modified the council and committee structure at CMS. Although there was an adjustment period, it seems to be a success. Dr. Bailey took the ideas from the 1993 Planning Conference seriously and has put forth the effort to make these ideas reality.

### ***Dr. Bailey should be proud of the way in which the new Health Affairs Council (HAC) has functioned.***

If you refer to HAC's Progress Report in this issue, I am sure you too will be amazed at the amount of work this council has undertaken and completed in the past six months.



# CMS Board Moves Toward Physician Network

## Physicians Work for Benefit of Their Patients

by Michael P. Thompson

1994, Gil Maestas, II



The Board of Directors of the Colorado Medical Society has taken bold steps toward establishing a statewide, physician-run health care network. At a special meeting August 5, the Board

voted to make

specific recommendations to the House of Delegates for consideration by the House at the upcoming 1994 Annual Session.

The impetus for this proposal came from a Resolution passed by the House of Delegates at the Annual Session in 1993. The original Resolution maintained that a physician-managed health care network would be the "high quality, low cost provider of health care in Colorado."

The Board echoed that belief, adopting the Mission Statement proposed by the Network Task Force, "The Colorado Medical Society believes that a physician directed managed care organization can produce superior quality and efficiency while maintaining the integrity of the traditional physician/patient relationship."

The general idea is that physicians know better how to provide quality medical care than insurance executives, clerks and bureaucrats, and that to leave the authority to make health care decisions in the hands of people whose main con-

cern is the bottom line presents a growing conflict of interest for physicians, whose main interest is the welfare of their patients. Only by taking control of the process can physicians hope to have the clout to protect their patients, while still being financially efficient.

At last year's Annual Session, the House directed the Board to gather information on the concept of a statewide IPA. At the Interim Session the concept was expanded to include any sort of managed care organization and the Task Force was authorized to conduct a scientific survey of CMS members to determine how much support exists for the idea.

The survey was carried out by Monaghan and Associates. James Monaghan reported to the Board on the results. Generally, physicians thought the idea was good, but were not overly optimistic that it would work. The results showed that if top-notch management was procured and a significant portion of the contract care in the state was included, the program had a good chance of success. However, this is at least partially a Catch-22 situation. The success of the program depends mostly on how many CMS member physicians support it, but their support is largely based on how successful it is.

With that in mind, the Board proposed step two in the process: a feasibility study. Some Board members were uncomfortable with making a recommendation that did not include specifics on what kind of plan is developed, i.e. IPA, HMO, PPO or what. However, the answer

*Wm. Carl Bailey, MD, CMS President, David C. Martz, MD, CMS President-Elect, and John F. Farrington, MD, Chair of the Network Task Force listen to the opinions of their medical colleagues regarding the formation of a statewide, physician-run health network.*

***"I now know more about managed care than I ever cared to.***

*John F. Farrington, MD*

to this question depends on the results of the feasibility study. Respondents to the survey indicated a variety of opinions on the structure of the program, but were mostly concerned with the question of what will work. The feasibility study will determine what kind of plan has the best chance of success, and how to structure it.

The feasibility study is a bit more expensive than the membership survey, which was paid for out of budgeted funds. An assessment of \$50-100 per member will be required to defray the cost of the proposed study and other developmental expenses. This will be discussed and voted upon at the Annual Meeting.

The original IPA Task Force was chaired by then President Leigh Truitt, MD. Since Dr. Truitt has now moved to Charlotte, North Carolina and the scope of the project has been broadened to include whatever type of managed care structure seems most appropriate, the name of the group was changed to "Network Task Force", now chaired by John Farrington, MD, past president of CMS and a recognized authority on managed care, especially IPAs. As Dr. Farrington told the Board, "I now know more about managed care than I ever cared to."

Dr. Farrington presented the Board with proof that an organization run by physicians could provide

quality care much more efficiently than a traditional managed care organization. For instance, peer review of outcomes and protocols has been used successfully as a management tool and has produced far more beneficial changes in physician behavior than retrospective review by insurance companies. The group commended Dr. Farrington and his group for their tireless and effective efforts in spearheading this project.

In addition to directing Dr. Farrington and the CMS staff to write a Resolution for consideration at the Annual Meeting, the Board adopted the goals and objectives proposed by the Network Task Force:

## Goals

1. Improve the value of health care delivered.
2. Facilitate the ability of the patient to choose a high quality physician.
3. Compete on the basis of value and quality.
4. Optimize physician/patient roles in clinical decisions.
5. Enhance physician access to patient populations.

## Objectives

1. Develop a sound business plan

This would include but not be limited to the following activities:

- Conduct market analysis (membership survey, feasibility study)
- Develop governance and structure
- Develop financing options
- Develop reimbursement mechanisms

2. Develop Clinical and Administrative Information Systems
3. Develop Outcome Analyses and Promote Quality Improvement via Feedback and Education

The feasibility study and other recommendations of the Board will be considered in Reference Committee and by the House of Delegates in Beaver Creek September 9-11. If you have not already registered, call immediately—303-779-5455 or 1-800-654-5653.



*Jim Monaghan presents the results of the member survey*

1994, Gil Maestas, II



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## HOUSE OF DELEGATES

# RESUMÉ

### Reports & Resolutions to be Considered Colorado Medical Society

**Annual Meeting**  
**Hyatt Regency Beaver Creek**

**September 9 - 11, 1994**  
**Beaver Creek, Colorado**

#### OFFICIAL CALL:

The 124th Annual Meeting of the Colorado Medical Society will be held at the Hyatt Regency Beaver Creek, Beaver Creek, Colorado. The first meeting of the House of Delegates will convene at 9:00 AM on Friday, September 9, 1994. The second meeting of the House will convene at 8:30 AM on Sunday, September 11, 1994.

Sandra L. Maloney  
Executive Director

This résumé is a brief description of some of the activities which will occur during the Annual Meeting. We encourage the membership of CMS to participate in these meetings for several reasons. By attending the Reference Committee meetings and voicing your opinions on the issues being discussed, the leadership of CMS can be assured that we are truly representing the membership of the CMS as we seek to influence the direction of organized medicine in these times of ever-changing medical practice. Secondly, by attending the informational sessions and general membership meetings, you become informed about current issues. Thank you for your consideration of these matters.

#### REFERENCE COMMITTEE ON BOARD OF DIRECTORS/CONSTITUTION, BYLAWS & CREDENTIALS

**RES-33-A - Essay Contest on Health Care Reform**

..... **Resolves that the** Colorado Medical Society sponsor an essay contest on health care reform with monetary rewards for 1st, 2nd and 3rd place entries.

**RES-37-A - Encouraging Multiple Nominees for CMS Offices**

..... **Resolves to increase efforts to provide multiple candidates** for elective offices in the Colorado Medical Society.

**RES-38-A - Regional Representation of the Colorado Medical Society President-Elect**

Resolves that the nominations for the President-Elect be selected collectively from the Denver, Arapahoe, Boulder, Clear Creek and Aurora-Adams Medical Societies two out of every three years.

**RES-55-A - Increase Membership and Revenue**

..... Resolves that the Component Societies Presidents meet to discuss ways and means to increase the Colorado Medical Society membership.

**RES-59-A - Rules of Order**

..... **Resolves that the** Colorado Medical Society adopt the Rules of Order published by James E. Davis, M.D., as its standard rules of order for all meetings.

**RES-64-P - Sharing Disciplinary Action Information with Other Medical Societies**

..... Resolves that the Colorado Medical Society develop policy that requires the sharing of adverse information about a member physician with the county society to which the physician is transferring.



- RES-65-A - Membership Dues Increase**  
 ..... Resolves that the Membership Dues for Active Members be increased.
- RES-66-A - Bylaws Amendment - Drop Date for Non Payment of Dues**  
 ..... Resolves that the drop date not non payment of dues be changed from February to January.
- RES-67-P - Encouragement of Physician Participation in Project USA**  
 ..... Resolves that the Colorado Medical Society encourage Physician participation in Project USA.
- RES-68-A - Bylaws Change/Nominating Committee**  
 ..... Resolves that the Nominating Committee shall indicate the most qualified candidate.
- RES-69-A - Elimination of Interim Meeting**  
 ..... Resolves that the Interim Session of the House of Delegates of the Colorado Medical Society be eliminated.
- RES-73-A - Survey on Demographic Physician Data**  
 ..... Resolves that the Colorado Medical Society apply for grant monies to fully fund the cost of a study to detail the demographics of physician practice in Colorado.
- RES-75-A - Bylaws Amendment - Council on Legislation**  
 ..... Resolves that the current President of the Colorado Medical Society Alliance be included as a member of the Council on Legislation.

#### REFERENCE COMMITTEE ON HEALTH AFFAIRS

- RES-34-P - Profiteering in Health Care**  
 ..... Resolves that the Colorado Medical Society publicly condemn excessive profits, bonuses, and other excessive gratuities which in our view serve only to increase the cost of medical care without enhancing the quality of care.
- RES-44-P - Non-Physician Providers**  
 ..... Resolves that the Colorado Medical Society adopt as policy a statement which describes the education and scope of practice for non physician providers recommended by CMS.
- RES-45-A - Sunset of Non-Physician Provider Policies**  
 ..... Resolves that current policies for non-physician providers be sunset if RES-44-P is adopted.
- RES-46-P - Corporate Practice of Medicine**  
 ..... Resolves that the Colorado Medical Society adopt a policy on the corporate practice of medicine.
- RES-47-A - Bylaws Change - Committee on Professional Education and Accreditation**  
 ..... Resolves that the Bylaws be changed to reflect the new name of the Committee on Professional Education and Accreditation.
- RES-12-P - Colorado Statute Concerning Managed Care Companies**  
 ..... Resolves that the Colorado Medical Society active pursue an amendment to existing Colorado Statute which will require written confirmation (via fax or other means) on the same day that decisions are made regarding the denial or authorization of benefits regarding a proposed treatment.

### 1994 ANNUAL MEETING EDUCATIONAL PROGRAM

#### "Here's Looking At You, Doctor"

**Saturday, September 10, 1994, 8:00 am - 11:30 am**

Our title may be a friendly salutation in some circles, but when you change it ever so slightly to "Who's Looking at you, . . ." it can be threatening. This Educational Program will help you identify everyone who looks over your shoulder as you practice medicine and how helpful these gatherers of practice data might or might not be. "Who's Looking at you . . ." might be one of the most important educational programs CMS has ever had.

## Council on Legislation Progress Report

The Council on Legislation prioritized 61 state legislative proposals this past year. 52 of these bills were supported by CMS and nine were opposed. 33 of the bills supported by our society were passed into law; 18 were killed and one bill which we supported was vetoed by the governor. We opposed nine bills; seven of these were killed and two were amended to address our major concerns and then passed.

The Council identified 10 bills as having high priority for CMS. The positions and outcomes of these bills are listed below.

### **SB 199. Concerning Workers'**

**Compensation (Norton):** This bill was introduced late in the session and represented a compromise between the business and labor communities regarding amendments to SB 218 ('91).

**Comments:** CMS opposed an extension to the fee freeze contained in the bill and the absence of an appeals mechanism for providers removed from the Workers' Compensation system. We were able to amend the bill to include the appeals mechanism but the fee freeze was extended until July 1, 1995.

**HB 1022, Naturopathic Health Care Practice Act (George):** This bill would have allowed for licensure of naturopaths who could (1) serve as primary care physicians, (2) prescribe "naturally based" substances, (3) perform "minor office procedures", and (4) practice naturopathic childbirth with a certificate of specialty practice.

**Comments:** CMS strongly opposed this bill and was able to kill it in the first committee hearing. We can expect a similar proposal to surface in the future.

**HB 1081, Advanced Practice of Nursing (Entz):** Allows for establishment of a registry of advanced practice of nursing.

**Comments:** The original version of this bill contained a clause which may have provided for prescription

privileges for advanced practice nurses. When this clause was removed, the Council voted to support the bill which passed and was signed by the governor.

**HB 1136, Prohibition of Smoking in State Buildings (Kreutz):** The measure was intended to prohibit smoking in all state buildings, including the state capitol.

**Comments:** This measure was supported by CMS and was passed with an amendment which allows the State Legislative Council to make exceptions to the law. CMS is working with the Council to assure that any excepted area is well-ventilated.

**HB 1186, Measures to Enhance Cost Containment in the Health Care System (Prinster):** One of three bills in a package of proposals aimed at Colorado health care reform. The other bills are HB 1193 and HB 1210 which are described below.

**Comments:** CMS voiced serious concerns regarding the section which dealt with the definition of a primary care physician - we do not believe that such a definition should be placed in statute. The bill was killed in House Appropriations Committee.

**HB 1193, Creation of Health Care Coverage Cooperatives and Provider Networks (Foster):** Sets forth mechanisms for the creation of health care coverage cooperatives and provider networks. It establishes procedures for the organization and dissolution of such cooperatives and networks.

**Comments:** CMS did not oppose HB 1193 but voiced our concerns that (1) we support employee ownership and choice of policies; (2) insurance reform would be the preferred alternative, and (3) we have reservations concerning the cost effectiveness of this bill. We are successful in attaching an amendment which states that licensed professionals are not required to exclusively refer any patient to a particular provider or supplier or take any action the professional determines not to be in the patient's best interest. HB 1193 passed.

**HB 1210, Measures to Improve the System of Financing Health Care**

**Costs Using Arrangements with Private Third-Party Payers (Cofman):** The bill requires individual and small employer carriers doing business in the state to offer at least the basic and standard health benefit plan coverages which are being proposed by the Cost Containment and Guaranteed Access Commission.

**Comments:** CMS supported this proposal which limits the preexisting conditions clauses contained in many policies and provides for portability of coverage when employees change jobs. HB 1210 passed.

**HB 1231, Regulation of Emergency Medical Services (Tanner):** The CMS opposed this bill which we believed placed costly restrictions on the provision of emergency medical services. The bill was killed in House HEWI Committee.

**HB 1300, Board of Medical Examiners (Pierson):** This bill required the BME to investigate cases in which physicians have had an adverse action taken in another state against their licenses. It required physicians to post the phone number of the BME in their offices.

**Comments:** CMS worked with the sponsor to assure that we could live with the amended version of this bill but HB 1300 was killed in committee. A consumer group continues to pursue legislation which will require the BME to publish the names of all physicians who have had complaints filed against them. We expect this same group to continue their efforts towards obtaining copies of responses to the '20-day' letter and access to tapes of investigatory hearings.

**HB 1342, Minimum Mandatory Automobile Insurance Coverages (Epps):** Reduced the amount of liability, medical expense and rehabilitative expense coverage required by Colorado law.

**Comments:** CMS opposed HB 1342 and the bill was killed.

### **CMS Medical Practice Act Task Force:**

The Task Force has not met since the CMS Interim Meeting because



members were waiting for the Department of Regulatory Agencies Sunset Review of the Act. The review was completed in late June and Dr. Steve Thorson, Chairman of the CMS Medical Practice Act Task Force, did a superb job of testifying on behalf of CMS at the Sunset Review Hearing. The Task Force will meet on August 24 to review the draft piece of legislation which will be submitted to the Sunrise/Sunset Review Committee for approval.

Once approved by the Committee, the bill will be submitted to the 1995 legislature for action. We do not expect to have major problems with the proposal which will be offered by the committee, but the Task Force will be closely monitoring the bill as it winds its way through the legislature to assure amendments detrimental to our profession are not attached.

#### **Coalition of Medical Specialties**

CMS leadership strongly supported the creation of the Coalition of Medical Specialties and the group held 3 meetings. Problems arose when meeting attendance dropped drastically and there was little continuity of attendees. A decision was made to disband the group until the goals and problems encountered with the coalition can be assessed.

#### **Sunrise/Sunset Review**

The Chiropractic, Nurse, and Podiatric Practice Acts are being reviewed by the Legislative Sunrise/Sunset Committee. The recommendations of the Department of Regulatory Agencies (DORA) on the Chiropractic Practice Act did not contain any surprises nor attempt to increase the scope of practice for chiropractors. The Podiatric Practice Act review has not yet been completed.

The DORA review of the Nurse Practice Act was carefully analyzed by staff and members of the CMS Mid-level Provider Task Force. Dr. Trish Byrns testified on behalf of CMS and her testimony was extremely well received by Sunrise/Sunset Committee members. The committee asked that representatives of the nurses, medicine and pharmacy meet during the month of August and discuss when prescriptive privileges

for nurses may be warranted. The group is holding weekly meetings to determine if an agreement may be reached on this subject.

#### **Federal Legislation**

Federal legislative activities are being continually monitored and any action requested by the AMA is referred to the appropriate CMS Council/Committee/Task Force.

#### **Other Activities**

Voting records for the 1994 legislative session have been compiled and are available through the CMS Department of Government Relations. In lieu of publishing a brochure containing these records as we have done in past years, the legislative arm of the society published a legislative wrap-up which was distributed to the entire CMS membership.

#### **Directives of the House**

##### **RES-39-P (AM '93), CMS Involvement in Trauma System Development and Legislation**

**RESOLVED**, that the Colorado Medical Society (CMS) play an active role in the design and implementation of an integrated statewide trauma system which is consistent with recognized standards and work for the development of a fair and effective trauma system; and be it further

**RESOLVED**, that CMS take appropriate legislative action to assure the passage of such a trauma system.

**Comments:** SB 103, Concerning Emergency Medical-Trauma Services Throughout the State, set forth the mechanisms for establishment of a Statewide Trauma System. As the bill made its way through the legislative process, it was drastically amended. The bill, as passed, calls for establishment of a task force consisting of members of the legislature to provide advice to the Emergency Medical Services Division of the Department of Health with regard to development of the system.

##### **RES-41-P (AM '93), Genetic Information**

**RESOLVED**, that in order to protect the privacy and preserve an individual's autonomy with regard to the individual's genetic information, it is appropriate to enact state laws that limit the use and availability of such information; and be it further

**RESOLVED**, that all genetic information shall be deemed confidential and privileged. Such information may be sought with consent of the individual for therapeutic or diagnostic purposes. Notwithstanding the foregoing, genetic information may not be sought for non-therapeutic purposes by entities engaged on health or disability insurance underwriting or employment hiring and decision making, except as noted below; and be it further;

**RESOLVED**, that it shall be unlawful for any entity, including employers, insurance companies, and health maintenance organizations to utilize genetic information for any non-therapeutic purposes, or if in possession of genetic information, to release such information to third parties, without the explicit consent of the individual to whom such information pertains; and be it further

**RESOLVED**, that notwithstanding the provisions above, genetic information with respect to a person who is a subject of a criminal investigation or criminal prosecution may be disclosed to police officers or any other person conducting such investigation or prosecution, and may be utilized during the course of a criminal prosecution with respect to the individual to whom such information pertains, without the consent of such individual; and be it further

**RESOLVED**, that the Colorado Medical Society work in collaboration with the Commission of Life and the Law to seek legislation and lobby to assure the passage of such legislation which will affirm the privacy, the preservation of an individual's autonomy and the confidentiality of genetic information.

**Comments:** SB 58, Concerning Limitations on Genetic Testing, was

passed by the 1994 legislature and accomplishes CMS' policy as stated above.

**RES-12-P (IM '94), Colorado Statute Concerning Managed Care Companies**

**RESOLVED**, that the Colorado Medical Society shall actively pursue an amendment to an existing Colorado statute (Title 10, Article 19) concerning managed care companies, this amendment to specify that:

After the managed care company has communicated a decision to the physician's office, the physician or his representative may request confirmation by printed document. This confirmation will be sent the same day, will contain decisions made in regard to benefits, authorization, pre-authorization, acceptance and/or denial of services, the reason for denial, and any other administrative decisions made in regard to the patient's proposed treatment. This confirmation shall contain the name, phone number, extension, and signature of the person responsible for rendering the decision.

**Comments:** This resolution was passed after the legislative deadline for introduction of new bills, thus it will be an agenda item for the first meeting of the Council on Legislation. The council will work closely with the Health Care Reform Task Force in addressing this resolution.

**RES-16-P, Safeguards for Physicians in Health Care Plans**

**RESOLVED**, that the Colorado Medical Society adopt as policy, and work to incorporate in all health system reform legislation, the following positions: 1) all managed care plans and medical delivery systems must include significant physician involvement in their health care delivery policies similar to those of self-governing medical staffs in hospitals, and 2) any physicians participating in these plans must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance proce-

dures, credentialing criteria and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

**Comments:** This resolution was passed after the legislative deadline for introduction of new bills, thus it will be an agenda item for the first meeting of the Council on Legislation. The Council will work closely with the Health Care Reform Task Force in addressing this resolution.

**RES-22-P, Insurance Industry Legislation**

**RESOLVED**, that the Colorado Medical Society call for legislation requiring the insurance companies and agents to obtain informed consent from each subscriber detailing how their insurance plan is likely to impact or restrict their health care needs; and be it further **RESOLVED**, that the Colorado Medical Society will call for an end to "preexisting condition" clauses in health insurance contracts and call for "community rating" as the means for setting the premiums.

**Comments:** HB 1210 limits the preexisting condition clauses contained in many policies. RES-22-P was passed after the legislative deadline for introduction of new bills, thus it will be an agenda item for the first meeting of the Council on Legislation. The council will work closely with the Health Care Reform Task Force in addressing this resolution.

**LATE RES-30-P (IM '94), Implementation of CMS Policy regarding "Point of Service Option" to Managed Care Contracts**

**RESOLVED**, that the Colorado Medical Society go forward in submitting the following "Point of Service Option" amendment to be added to a current health insurance related bill in the current Colorado Legislature: (this language would be included in a section regarding requirements for plans that restrict access to providers)

Each plan that restricts access by enrollees or members to health care providers shall offer enrollees or

members coverage for health care services provided by out-of-network providers through an alternative "Point of Service Option" coverage. In the case of an enrollee who elects this "Point of Service Option" coverage, the plan may charge an alternative premium to the enrollee or member to take into account the actuarial value of such coverage. If the plan, because of federal law, cannot charge a higher alternative premium, then such plan will not come under this statute.

The Colorado Medical Society shall work with the legislature and interested parties to develop a benefit payment system which will provide a reasonable level of benefit for the patient. Such benefit level should not be set so low as to act as a prohibitive deterrent to patient utilization of this 'point of service option'.

**RESOLVED**, that the Colorado Medical Society shall instruct the Council on Legislation to work expediently to develop and implement a lobbying plan designed to maximize the chances of passage of this amendment; and be it further **RESOLVED**, that if the Colorado Medical Society is unsuccessful this year in passing a "Point of Service Option" amendment in the Colorado Legislature, the Legislative Council will work with our Colorado Legislators to present a "Point of Service Option" amendment to the 1995 session of the Colorado Legislature.

**Comments:** CMS representatives approached the sponsor of HB 1193 concerning amending that bill to include the "Point of Service" option. Since the bill was moving rather smoothly through the legislature, the bill sponsor was not interested in adding this amendment. A CMS task force is being formed to develop a health care reform proposal for the 1995 legislative session which will embody this concept.

**SUB RES-31-P (IM '94), Smoking Ban**

**RESOLVED**, that the Colorado Medical Society urge the Colorado Department of Health and Colorado Legislature to prohibit smoking in all



restaurants and public places in the State of Colorado.

**Comments:** The council will be addressing this resolution at its first 1994/95 meeting. Passage of HB 1136 was a first step towards eliminating smoking in public places.

Respectfully Submitted:

Fred A Lewis, Jr., MD, Chairman  
H.G. Butler III, MD  
Sally Coates, MD  
Guillermo Davila, MD  
Peggy Fogel  
W. Ben Galloway, MD  
Diane Glismann  
Stewart Greisman, DO  
Mary Jo Jacobs, MD  
Gene Jacobson, MD  
Sherri Laubach, MD  
M. Ray Painter, MD  
James Shira, MD  
Daniel Thatcher, MD

## COMPAC Progress Report

The COMPAC Board of Directors has been very busy in this election year with membership being a main thrust. Membership recruitment activities have included the production of a COMPAC video which has been shown at many county medical society meetings. (If any COMPAC member would like the video shown at their local membership meetings, please notify the Dept. of Government Relations.) With the current atmosphere of medicine, and health care reform looming on the horizon, it is more important than ever that COMPAC have a large member and financial base in order to flex an adequate amount of influence in this years' elections.

Membership has increased this year, however, only approximately 10 percent of the Colorado Medical Society's members are COMPAC members. This percentage should cause concern to any physician who hopes to have an impact on health care reform.

## State Legislative Races

The COMPAC Board of Directors has been meeting and reviewing both primary and general election races at the state level. This year there are an extraordinary number of candidates facing primary elections. COMPAC has responded by contributing approximately \$4,000 to these candidates and will be involved in sponsoring or assisting with a number of local political fund-raisers. At the time this report is being drafted, COMPAC has become involved in 8 state races; 5 of which are Republican and 3 of which are Democratic.

## Federal Legislative Races

On the national level, COMPAC made a recommendation to the American Medical Political Action Committee (AMPAC) for endorsements in the 2nd, 3rd and 4th Congressional Districts. AMPAC has responded with early contributions to Congressman Scott McInnis in the 3rd Congressional District and Congressman Wayne Allard in the 4th Congressional District. Four Republicans will be vying for the Republican nomination for the 2nd Congressional District seat currently held by Congressman David Skaggs (D). All candidates were invited to appear before the Board for an interview. Candidate Pat Miller stated she was not interested but interviews were conducted with the other three candidates: Ted Engle, a Lakewood physician; Sharon Klusman, a financial planner from Evergreen; and Michelle Lawrence, a businesswoman, State Representative, member of the House HEWI Committee and good friend of medicine.

The Board found each of the three to be excellent candidates and members deliberated at length before determining on a vote of 9 to 2 to recommend that AMPAC support Sharon Klusman. AMPAC responded with a contribution of \$5,000.00 to the Klusman campaign.

Consideration of additional candidates will continue. Who will occupy 83 of the 100 state legislative

seats will be determined in this November's election: 18 for the State Senate and 65 for the State House of Representatives. COMPAC will most likely become involved in the majority of these races. An update of COMPAC's involvement will be distributed at the Annual Meeting.

Respectfully Submitted:

Robert Sawyer, MD. Chair  
Robert Bogin, MD  
Joseph Bonelli, MD  
Patti Brown  
Richard Bryan, MD  
John Buglewicz, MD  
H.G. Butler, III, MD  
Francis Candlin, DVM  
Ghodsi Daneshbod-Skibba, MD  
Lisa Fox, MD  
W. Ben Galloway, MD  
Diane Glismann  
Jan Holman  
Robert L. Kruse, MD  
Fred A. Lewis, Jr., MD  
Alethia Morgan, MD  
Joseph Pollard, Jr., MD  
Alan Rapp, MD  
John Santoro, MD  
Carol Sides  
John Steinbaugh, MD  
John S. Tarr, Jr., MD  
Harry Wherry, MD  
Harold Yocum, MD

# Report of Health Affairs Council

The Health Affairs Council (HAC) has been meeting monthly since December of 1993. Its charge is to study the provision of medical care and the changing conditions and anticipated proposals affecting the practice of medicine. Such issues shall include, but not be limited to, matters concerning the provision of quality medical care, socioeconomic issues, public health issues, data collection, analysis and dissemination and third party payer issues. The Council shall recommend and promote policies to CMS, when appropriate. At this time, the following committees and task forces report to the Council: Health System Reform Task Force, Data Task Force, Committee on Professional Education and Accreditation, Rural Health Task Force, Youth Task Force, and the Workers' Compensation Advisory Committee. Additional task forces have been utilized to develop policies in particular areas such as the corporate practice of medicine, non-physician providers and credentialing. HAC has also established ten on-call task forces potentially involving over 50 physicians who can be called upon as needed to address a variety of topics.

In March of this year, the Council determined their priorities to be as follows:

Under the rubric of SOCIO-ECONOMICS -

## 1) Quality/Data:

The Data Task Force was asked to develop recommendations regarding CMS activities in the area of data and quality initiatives. Their recommendations were reported to the Health Affairs Council in June and include efforts in the areas of 1) member education, 2) policy development support, 3) physician office automation, and 4) small area analysis. Subcommittees on the latter two items are working to further develop proposals in these areas and will report back to the task force in September.

Additionally, the position and background papers on physician-specific data which were completed and approved by HAC and the Board will be handed out at the educational program on Saturday, September 10.

## 2) Allied Health:

A non-physician provider task force was created to develop policy for CMS. The result of their work is presented in RES-44-P. With the adoption of this proposed policy this task force will have completed its work and will not continue to meet.

## 3) Health System Reform:

The task force has expanded and clarified the CMS Health System Reform policy and is submitting a resolution to the House of Delegates for approval. The task force developed a document which summarizes the CMS priorities within health system reform. This will help in communicating with legislators as well as CMS membership about our positions on health system reform. The task force has discussed its desire to focus on education and continue to develop meaningful ways of educating CMS membership, legislators and the public regarding health system reform and our policy regarding it.

The task force is working in conjunction with the Council on Legislation in response to a request from the Board of Directors to determine what a CMS sponsored health system reform legislative proposal should embody. The two groups will be working jointly to develop legislation which is hoped to be introduced in the 1995 legislative session.

Under the rubric of PUBLIC HEALTH -

## 4) Rural Health:

Recognizing that CMS needs to do a better job of addressing rural health needs, HAC determined this to be a priority for CMS activity. A rural health task force was created, chaired by Dr. Jack Berry of Wray, Colorado. Rural health meetings were held in Rocky Ford (4/27), Craig (5/12), Brush (6/1) and Cortez (6/21) to discuss with CMS members ways in which CMS could assist rural

physicians and rural health care. Recommendations for CMS activity in the area of rural health were provided to the Health Affairs Council in July and subsequently submitted to the House of Delegates as RES-51-P.

## 5) Youth:

The newly-formed Task Force on Youth is composed of CMS members and representatives of the Alliance. It was convened in order to recommend and subsequently undertake a project that would impact youth statewide. The Task Force has had two meetings thus far.

After discussing numerous ideas for projects the Task Force agreed to submit a resolution to the House of Delegates at the Annual meeting recommending that the Task Force pursue a project on comprehensive K-12 health education which would allow CMS-wide involvement in its various facets including, community program planning, educational consultation, advocacy and promotion and provision of education. The resolution also recommends that the Task Force explore collaborative relationships with other organizations that are providing comprehensive health education in the schools. (The Rocky Mountain Center For Health Education and Promotion, the major provider of comprehensive health education in Colorado, was recently awarded a five-year, 6.2 million dollar grant by the Colorado Trust. The money would allow the Center to expand its efforts to provide comprehensive health education in schools throughout the state. Representatives of the Rocky Mountain Center have invited CMS to collaborate with them in these efforts.)

The Task Force on Youth also submitted resolutions to the House of Delegates which 1) encourage physicians to participate in the community planning process of school-based health centers and 2) encourage physician participation in the new federally-funded Vaccines For Children program. Under the rubric of THIRD PARTY PAYOR ISSUES -



## 6) Managed Care Policy Development:

The Health Affairs Council determined that managed care issues would be an ongoing priority topic under their purview. The first undertaking was to revise and consolidate existing managed care policies and to respond to RES-17-P from the '94 Interim Meeting.

### **RES-17-P: Health Care Plans**

**RESOLVED**, that Colorado Medical Society (CMS) adopt the following statements regarding freedom of choice issues:

- citizens of Colorado must be afforded freedom of choice of physicians and choice of health care delivery systems;
- the public should be educated on the various types of delivery systems;
- employers should offer employees a choice of health plans;
- CMS should express concerns regarding health programs that impair continuity of medical care;
- any restrictions applied by a health plan shall be clearly identified to the individual prior to their selection of that system;
- the freedom of patients to select and to change their physician or medical care plan should extend to those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services, and be it further

**RESOLVED**, that CMS adopt the following statements regarding the fundamental elements of the patient-physician relationship:

- physicians are the primary patient advocates, are not rationers of medical care, and will continue to utilize diagnostic and therapeutic measures and facilities in the best interest of the individual patient;
- the fundamental elements of the patient-physician relationship include the patient's right to courtesy, respect, dignity, responsiveness and timely attention to

his or her needs, and be it further **RESOLVED**, that CMS adopt the following statements regarding physicians' ability to participate in health care plans:

- physicians should have the right to apply to any health plan or network in which they desire to participate and to have that application approved if it meets physician-developed and approved objective criteria that are available to both applicants and enrollees and are based on professional qualifications, competence, quality of care and as well as cost efficiency of care;
- CMS acknowledge that health care plans or networks may develop and use criteria to determine the number, geographic distribution and specialties of physicians needed;
- CMS advocate strongly that managed care organizations and third party payers be required to disclose to physicians applying to the plan, the selection criteria used to select, retain or exclude a physician from a managed care plan, including the criteria used to determine the number, geographic distribution and specialties of physicians needed;
- CMS advocates strongly that those health care plans or networks that use criteria to determine the number, geographic distribution and specialties of physicians needed be required to report to the public, on a regular basis, the impact that the use of such criteria has on the quality, access, cost and choice of health care services provided to patients enrolled in such plans or networks;
- CMS advocate in those cases in which economic issues may be used for consideration of sanction or dismissal, the physician participating in the plan should have the right to receive profile information and education, in a due process manner, before action of any kind is taken;
- CMS support fair implementation of selective contracting criteria, procedures, and due process

rights by managed care organizations and third party payers;

- CMS is opposed to any federal effort to preempt state "any willing provider" laws, and be it further

**RESOLVED**, that CMS urge the AMA to continue its efforts regarding federal regulation of managed care plans, and be it further

**RESOLVED**, that CMS adopt the following statements regarding changes to relevant antitrust laws:

- CMS supports appropriate changes in relevant antitrust laws to allow physicians and physician organizations to engage in group negotiations with managed care plans;
- CMS, through the AMA, shall pursue enhanced roles for physicians in private sector health plans, including lobbying for appropriate modification of the antitrust laws to facilitate physician negotiation with managed care plans and for legislation requiring managed care plans to allow participating physicians to organize for the purpose of commenting on medical review criteria;
- CMS shall advocate strongly to the Congress, the Colorado General Assembly, and other appropriate entities, the need for changes in relevant antitrust laws to allow physicians and physician organizations to engage in group negotiations with collective purchasers, managed care plans, insurers and other payers.

**Response:** Resolution -17-P was not adopted but referred from the Interim Meeting '94 to the Health Affairs Council (HAC) for review. A review of current CMS policies on managed care and Resolution 17-P (IM '94) was performed. Resolution 40-P (AM '94), consisting of a combination of current policy and language from 17-P was developed for consideration at the Annual Meeting '94. RES-43-P (AM '94) was also developed using the last resolve of 17-P to create a policy regarding changes in antitrust laws.

A separate managed care issue

that is being addressed is that of affiliation and disaffiliation processes. Ongoing discussions concerning affiliation and disaffiliation of physicians with managed care plans were started through the Physician/Patient Advocacy Council and have fallen under the auspices of the Health Affairs Council. Drs. McCartney and Karlin, along with staff, continue to meet with representatives from the HMO Association in an attempt to develop a process that will guarantee fairness and communication between managed care plans and physicians regarding affiliation and disaffiliation.

### 7) **Credentialing:**

In response to member questions and concerns regarding the physician credentialing process, a Credentialing Verification Task Force, chaired by Charles W. Mains, MD was assembled to discuss credentialing issues including the feasibility of CMS creating a centralized credentialing verification service. The Task Force, made up of physicians and administrative people with expertise in physician credentialing, has met twice. It should be noted that a few county medical societies (i.e., Hennepin County, Minnesota; Maricopa County, Arizona; and El Paso County, Colorado) have implemented successful verification services, however, an attempt by the Maryland State Medical Society failed.

After much discussion about time, expense, and ability to have agreement by all organizations on standardizing the process, etc., the Task Force decided to recommend that developing a standard form to be used on a statewide basis would be a good first step in resolving many of the concerns of our physician members. Res-56-A was submitted to the Health Affairs Council, ratified, and respectfully forwarded to the House of Delegates for action.

### **Ongoing Activities:**

**Committee on Professional Education and Accreditation:** The Committee on Professional Education and Accreditation, chaired by LeRoy H. Stahlgren, MD, has met twice since

the Interim Meeting. The Committee approved accreditation/re-accreditation for Delta County Memorial Hospital, Veterans Administration Medical Center (Ft. Lyon), Rose Medical Center, Southwest Memorial Hospital and Sterling Regional Medical Center. Additionally, 23 annual reports were discussed and acted upon. The educational program for the Annual Meeting, "Who's Looking at You" was reviewed and approved for three hours of AMA Category 1 credit. AAFP credits were also applied for and approved for three hours of prescribed credit.

In response to RES-5-A, IM '94, a revised Review/Appeal Process was developed and approved by the Committee then forwarded to the Board of Directors for action at their September 8 meeting. In response to combining the CME and Accreditation activities, a new Committee charge was approved and forwarded to the Health Affairs Council and the Board of Directors. A revised CME Mission Statement has been approved by the Committee and forwarded to the House of Delegates for ratification. It is currently listed in the Bylaws at Chapter XXI, Section 4 and the Committee recommends that it be sunset from the Bylaws and placed in the Policy Manual under Chapter VIII, Professional Education (see RES-70-P).

Finally, RES-46-P regarding financial support of the CME Accreditation Program has been discussed at length. Numerous ideas have been investigated, and to assist, a survey was developed and sent to 17 selected state associations to which 16 replied. The question of billing surveyor expenses to organizations seeking accreditation/re-accreditation causes serious concern to members of the Committee. When fees were last raised in 1990 travel related costs were also the most difficult issues to address. We accredit several small, outlying organizations incurring expenses of airfare or significant mileage, occasional car rental, hotel costs and meals. We also accredit large organizations who are either located in Denver incurring no expenses or

located nearby incurring minimal costs. A two-tiered survey fee system based on the number of acute care beds was developed in 1990 that would, in total, offset expenses without having to bill individual organizations. The fee structure did indeed accomplish the goal of covering expenses until the 1993-94 year.

Since the duration of accreditation ranges from one to four years, there is not a set amount of survey fee money that can be counted on from year to year. Surveys due this past year involved fewer large organizations at the higher fee rate and more outlying organizations at the lower fee rate with higher expenses. The resolution stating that we "...seek to make it financially a self-supporting institution" implying that staff salary and fringe benefits are included put the Committee in a position of having to increase survey fees substantially, attempting to cut expenses substantially, and cutting back significantly on services provided. The Committee respectfully submits the following recommendations to be implemented effective October 1, 1994. The Committee further submits that it is unable to reach agreement on how to raise fees and reduce expenses to the extent that accreditation, including staff salary, become fully self-supporting at this time and requests that it be allowed to phase in the directive over a three-year period.

### **Background:**

#### **Actual Expenses:**

<u>1991</u>	<u>1992</u>	<u>1993</u>
\$7,839.60	\$7,750.99	\$4,239.44

#### **Actual Revenue:**

<u>1991</u>	<u>1992</u>	<u>1993</u>
(\$8,508.91)	(\$10,000.00)	(\$9,000.00)

Included in the expenses are all survey related costs (travel, photocopying, mailing, telephone, staff membership in the Alliance for CME and the Colorado Alliance for CME, subscriptions, attendance at one or two important annual conferences, Committee activity, etc.).

Excluded in the above expenses



are staff salary and fringe benefits. At present, one staff person is assigned to administrate the accreditation program. Between 65-75% of that staff person's time is devoted to accreditation annually. The remainder of time is spent on other CMS related activity. When staff salary and fringe are included in the expenses of the program, an additional \$18,000-22,000 in revenue will be needed to make up the difference.

### Recommendations:

- That a three-tiered survey fee be implemented based on "active" medical staff in a hospital and total membership in specialty societies and other medical groups:

Less than 100 = \$750.00 fee  
(13 organizations)

100-300 = \$1000.00 fee  
(14 organizations)

Greater than 300 = \$1500  
(7 organizations)

Note: Approximately one-third of the total 34 accredited organizations are re-surveyed per year. With the above fees, we would collect approximately \$11,000 per year.

Again, duration of accreditation awarded to organizations will determine amount we collect.

- That an annual report analysis fee be charged with the amount based on 10% of their survey fee: \$75-\$100-\$150

**Note:** If approximately two-thirds of our accredited organizations pay an annual report fee in a given year, we would collect about \$2325.

- That those who choose to joint sponsor be charged \$200 per event or series up to \$1000. The amount that would be collected is unknown at this time, but a low estimate would be \$2000 per year.

Total anticipated revenue (average) per year is \$15,325.

Total average revenue for the 1991-1993 period was \$9167.

The Committee will further discuss pilot testing a reverse site survey, charging for consultation (other than telephone inquiries), and other solutions.

**Medicaid:** Rescinding the Medicaid "Lower-of" issue is being pursued with Senator Blickensderfer, who is currently seeking decisions regarding violation of federal law from the Colorado Legislative Legal Services and the Attorney General. The matter may be pursued legislatively in 1995 depending on forthcoming decisions.

The CMS Department of Government Relations offered testimony to the Colorado State Board of Social Services outlining physician concerns with the mandatory electronic funds transfer (EFT) program which is part of the Automated Medical Payments system (AMPs). The Board was very receptive to physician concerns presented, and, realizing the devastation the Medicaid program could face if physicians opted out of the Medicaid program over the EFT issue, removed all reference to the EFT program from its rules. CMS then met with the Department of Social Services to discuss the, now voluntary, EFT program. Meetings continue on the AMPs system which Medicaid will implement later this year.

Ongoing Medicaid activity has been monitored at the Medical Assistance Reform Committee meetings, the Medicaid Advisory Committee meetings, the Primary Care Physician Provider meetings and the monthly Department of Social Services Board meetings.

### Workers' Compensation Advisory Committee (WCAC):

The WCAC continues to meet on a bimonthly basis. The Committee was very active at the legislature this year testifying against a fee freeze and asking for due process in a review section of Senate Bill 199. The WCAC continues to review proposed rule changes to the Colorado Code of Regulations and continues to make recommendations to the Division of Workers' Compensation.

Another issue which deals with hassles from attorneys towards physicians performing independent medical examinations (IMEs) has been brought before the WCAC. As

a result of numerous letters, the WCAC has developed two resolutions for the Annual Meeting in an attempt to reduce these hassles.

**CPR Project:** To date, more than 29,000 CPR directive forms have been mailed to physicians, home health agencies and certified health care facilities around the state. Over 390 bracelets and necklaces have also been ordered. Forms can be ordered from CMS at a cost of \$.50 per copy, plus postage at cost. CPR bracelets and necklaces are available through a vendor. Ongoing efforts to provide information to the public and physician communities continues. CMS staff responds to an average of 25 phone calls per month regarding CPR directives and continues to provide an average of 15 information packets per month to providers throughout the state. Recent changes in law now allow CPR directives to be completed for children.

### Other Activities:

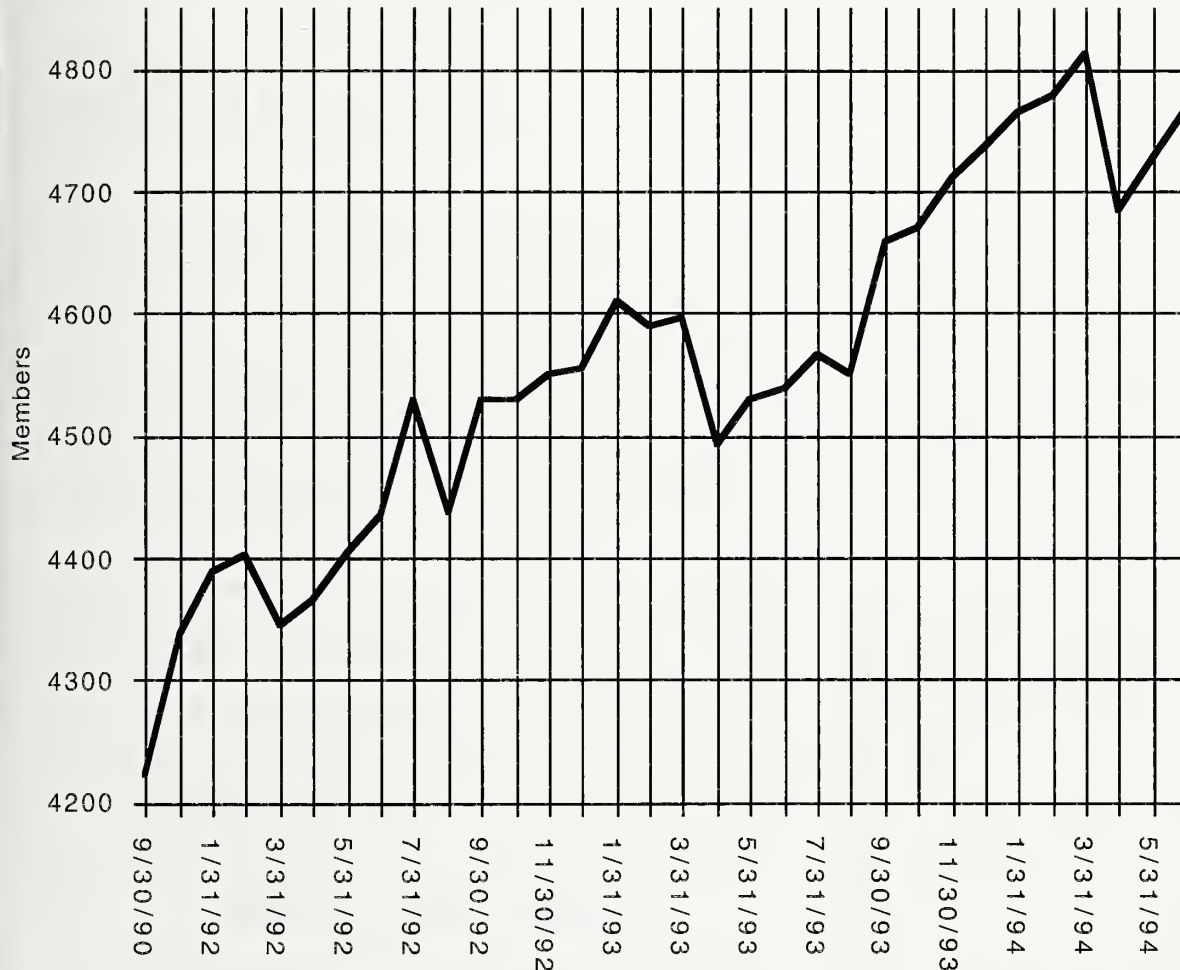
**Corporate Practice of Medicine -** Per request from the CMS Board of Directors and with the assistance of an ad hoc task force, CMS policy was developed with regard to the corporate practice of medicine. This proposed policy is submitted to the House of Delegates as RES-46-P. Members and staff continue to be liaisons between CMS and a variety of other agencies and organizations such as the Colorado Department of Health Violence Prevention Advisory Committee, Colorado Health Data Commission, Child Fatality Review Committee, Colorado Board of Health, Community Health Management Information System Committee, Rocky Mountain Heart Consortium, Blue Cross and Blue Shield as the Medicare carrier, Colorado Foundation for Medical Care (CFMC), Health Care Financing Administration (HCFA) and others. Staff also continues to disseminate immunization consent forms, "Guidelines for the Management of Concussion in Sports", OSHA information packets, etc.

## Membership

At the end of June, 1994, CMS had 4,768 total members. Membership is up 230 (5.1%) from June, 1993. Our potential membership is 4,915 (4,768 + 147 pending election). Membership hit an all-time high of 4,814 in March, 1994.

As of June 30, 1994 there were 147 members pending election. CMS has been working with the component societies to determine if there is a way to elect their new members in a more timely manner. During the summer months, it is difficult to handle elections as most county societies do not meet.

### CMS Membership Growth



*Note: Monthly detail prior to 1/92 is available in hardcopy*

A Membership Marketing Plan has been developed. The objective of this marketing plan is to increase membership in the Colorado Medical Society by marketing our products and services to the following:

- Group practice physicians working at Kaiser Permanente
- The MD and DO faculty at the University of Colorado Medical School
- Physicians in Residency training programs
- Female physicians
- Nonmember physicians that carry Copic malpractice insurance

These five target groups have been chosen because our market penetration into the first three is extremely low, the number of female physicians is increasing, and nonmember physicians that carry Copic insurance may save money by joining CMS.



## AMA Movement Report

We have implemented a system whereby all physicians that move into Colorado receive a welcome letter from us with an invitation to join their local component society and CMS. We mailed invitations to join CMS to 124 physicians that moved into Colorado during the first quarter of 1994. 21 of these have requested membership applications. Approximately 200 invitations to join CMS will be sent next week to physicians that moved into Colorado during the second quarter of 1994.

## BME Licensure Report

We are sending invitations to join CMS to all newly-licensed physicians in Colorado. This is done on a quarterly basis, corresponding with BME licensure. A mailing will go out next week to approximately 340 physicians. Half of these have out of state addresses, so we will send two different letters (one to instate doctors and one to out-state doctors).

## Copic Insureds that do not belong to CMS

Copic insureds that belong to CMS receive a discount of up to 10% off their malpractice insurance premiums. There are 696 physicians insured by Copic that do not belong to CMS. The premiums savings could easily exceed the membership dues. So far, 125 physicians have requested membership as a result of our marketing efforts. The names of the physicians that have not responded have been given to the Board of Directors for personal contact.

## Residents

The National Residency Match list was obtained from the AMA. Invitations to join CMS were sent to 171 residents that have moved to Colorado from other states

## Medical Student Component (MSC)

At the end of June, 1994, the CMS-MSC had 100 members. Membership is up 41 (66%) from 1992. The MSC is the 11th largest component society in the state.

Medical Students continue to be active at the House Of Delegates level. Three resolutions were submitted at the 1994 Interim Meeting, and MSC delegates continue to participate on Reference Committees.

The MSC will hold planning conference in Winter Park this August as an effective means to expand membership. The conference will also provide exposure to rural primary care by giving the students an opportunity to visit local physicians and clinics.

## Membership Update

Additional information was requested from each member this year on the *Directory Update* letter. We will be better able to segment our membership according to the information provided.

## Dues Billing

Master bills will be sent to hospitals that pay membership dues for their resident physicians. The member will receive a dues notice with AMA dues, COMPAC, and ERF.

## Department Streamlining

A multi-user database to track our recruitment efforts has been developed. The files are updated as responses are received. The database can be accessed at the same time, so we can immediately know how many responses we've received from what sources.

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the job you want.  
Unless, of course, you're  
too tired to lift a finger.

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Researching career opportunities takes time that you don't have. And often when you do, no one else is at work to help you. But the new **Practice Opportunity Line** offers an easy, no pressure, confidential way to conduct the search on your own, 24 hours a day. All you have to do is call, follow the prompts and research the openings. Then send a voice mail mini-resume to the opportunities you wish to pursue. It's fast. It's easy. And you're awake anyway.



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Opportunity Line**

We're on call for you.

from Physician's Market Information Center 1-800-423-1229

# School-Based Health Centers

## Introduction

The Colorado Medical Society Task Force on Youth will submit a resolution to the House of Delegates at the upcoming Annual Meeting which addresses the subject of school-based health centers. The resolution requests that the Medical Society: 1) recognize school-based health centers as an effective approach to reaching previously inaccessible children and adolescents with medical and mental health care needs; 2) encourage physicians to participate in the community planning process of school-based health centers; 3) support the efforts of the School-Based Health Center Initiative to obtain funding from the Robert Wood Johnson Foundation to allow existing programs to expand and/or new programs to begin providing services.

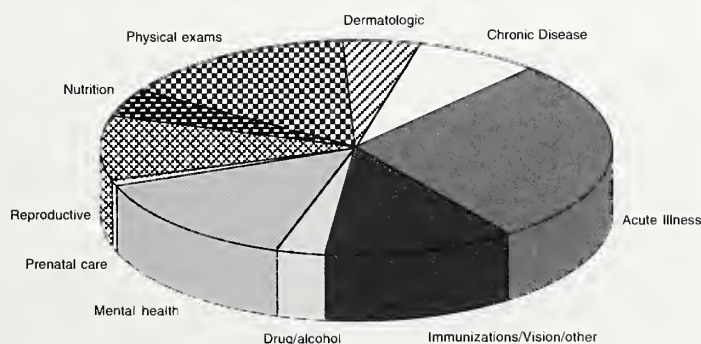
**Larry I. Wolk, M.D.**, a member of the Task Force, wrote the following article in order to provide members with some background information on school-based health centers, their history, goals, etc.

School-based health clinics have been providing care to students for just over twenty years, numbering over 500 in 41 states nationwide. Their utilization by students has been increasing as well, evidenced by the increase in annual clinic enrollment at the majority of sites. Many school-based centers provide the sole or primary health care source for nearly half of enrolled students.<sup>1</sup> This information is especially pertinent given the fact that some 4.7 million adolescents in the United States (or 15% of 10-18 year olds) are without any form of health insurance coverage.<sup>2</sup> In addition, some 7.5 million youth under the age of 18 years (12%) are in need of mental health services, but fewer than one-third actually receive treatment.<sup>3</sup>

In general, the services which school-based clinics

provide are not as controversial as one might think. A national survey of services provided by school-based clinics found that nearly one-third of services were for acute illnesses (figure 1). Reproductive and family planning services accounted for only 10% of all visits. Additionally, there is an increasing trend toward parental consent for the services provided as parents become more familiar with school-based clinics and staff (figure 2). The percentage of students whose parents consented to care at available school-based clinics rose from 34% during the 1987-88 school year to 71% during the 1989-90

**Figure 1**  
Health Services Provided  
School-based health programs



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# School Based Health Centers

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school year.

Colorado has been a leader in the school-based clinic movement since its inception. Community Health Services in Commerce City has been providing health care since 1978, distinguishing itself by participating in the first school-based condom availability program in the country. Community Health Services also serves as a national model for school-based clinics at the middle and elementary school levels. The Denver school-based clinics are in their fifth year of operation and continue to expand into medically underserved areas within metro Denver, most recently Montbello. Newer programs in Summit County, Fort Collins and the San Luis Valley are also providing school-based services.

The goal of school-based clinics is to make comprehensive medical and mental health services more accessible to children and adolescents. These services are not intended to replace those already provided by primary care physicians and/or mid-level providers. On the contrary, they usually augment local health care providers' practices by identifying students who have had little or no previous contact with a health care professional. In many cases, the school-based clinic staff acts as liaison between a student and his/her primary care provider. In some clinics, this may even be the

same individual, as many private practitioners participate as active school-based clinic staff members. In some communities, inappropriate emergency room utilization by adolescents has been impacted as a result of increased school-based clinic utilization, providing yet another reason as to the potential

providers should continue to support this innovative approach in reaching previously inaccessible adolescents and children.

*Larry I. Wolk, MD, MSPH is Medical Director for Ambulatory Pediatrics and Adolescent Medicine at Presbyterian/St. Luke's Medical Center and also Medical Director to Community*

*Health Services in Commerce City. He has consulted to community, school and health care provider groups interested in providing school-based clinic services. If you or your community are interested in learning more about school-based clinics, Dr. Wolk may be reached by calling (303) 869-2179.*

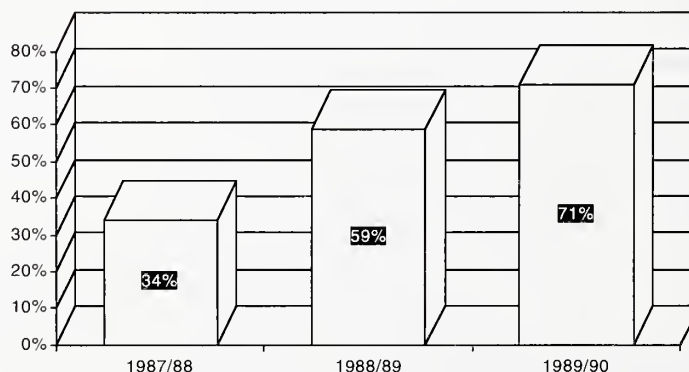
<sup>1</sup> Support Center for School-Based Clinics; Center for Population Options, Clinic News, Vol. 3, No. 3, 1987.

<sup>2</sup> Newacheck PW, McManus MA, Gephart J.

Health Insurance Coverage of Adolescents: A Current Profile and Assessment of Trends. Pediatrics 1992; 90:589-596

<sup>3</sup> Saxe LM, Cross T, Silverman N. Children's Mental Health: Problems and Services. Report prepared for the U.S. Congress Office of Technology Assessment. Durham, NC: Duke University Press; June, 1991

**Figure 2**  
**Parental Consent for Services**  
**School-based health programs**



benefits these services could offer.

The future of school-based health is promising. As much as \$100 million may be allocated in 1996 as part of the Clinton Health Care Reform package to school-based and school-linked health services. Colorado is also one of twelve states currently being considered for a sizable school-based health grant from the Robert Wood Johnson Foundation, which may allow existing programs to expand and/or new programs to begin providing services. As the trend in school-based health continues, physicians and other health care

# Child Care Alternatives

The United States is one of the few developed countries in the world which does not promote employer-assisted child care. at its 1993 Annual Meeting, the CMS House of Delegates passed a resolution asking the Women in Medicine Section to research existing models of child care in the workplace and make this information available to interested parties. I will describe these various models and generally comment upon America's child care situation.

Our society insists that parents care for their children themselves at all times and still compete in the market place with childless individuals. The current social climate of economic competition and rugged individualism is especially inhospitable to parenting. The more efforts parents direct towards their children, the less they are seen as committed to the work ethic. No one recognizes and rewards career sacrifice on behalf of young children. Instead, when this career sacrifice is made by women, we call it the "Mommy Track".

In Nordic nations the care of Children is regarded as a joint responsibility of parents and state. In Sweden, for instance, parents have a genuine choice between universally available quality child care and financial and social support for personal parenting by either mother or father. About 70% of women and 30% of men care for infants at home for at least 18 months. The Nordic nations view children as their greatest natural resource.

In contrast, our government leaves the responsibility for child care solely to parents as a matter of

individual concern and prefers to look the other way. During the 1980's the United States spent less than 5% of its federal budget on programs supporting families with children but 24% on persons 65 years and over. In 1991 58% of women with a child less than 6 years old were part of the labor force. A 1992 survey of 6,000 middle class American parents showed that in 53% of families with a child less than 5 years of age, one parent stayed home; 17% of those families used day care; 10% placed their child with a relative or neighbor; and 12% combined different types of care.

In this country the male model of the workplace persists, and it denies the existence of children. Our lack of quality day care deprives our economy of needed workers and our women of needed work. This lack negatively affects a whole generation of children raised in inadequate situations. The Carnegie Foundation now recommends up to four months of paid leave for all new parents after discovering that many of America's 12 million infants and toddlers are at high risk of stunted emotional and mental growth. The eventual effect of attachment disorders in childhood is evident in the violence on the streets of our major cities today.

Large employers in the USA should be required to establish their own child care center on site, subsidized in part by the employer and in part by the employee. Government funding should eventually become available for this purpose, perhaps beginning with a tax incentive. The Carnegie Foundation's



1994, Gill Maestria, II

*Deborah Bublitz, M.D.  
Chair-elect, CMS Women  
in Medicine Section*



# Child Care Alternatives

*from previous page...*

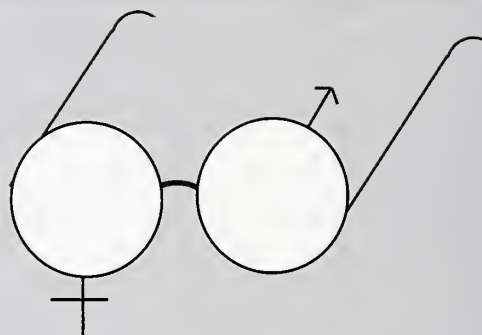
alarming findings point out that we cannot delay this approach much longer.

Should employers financially unable to support their own child care center should form a coalition with other small employers to establish a centrally located child care facility easily accessible to all their employees.

Not all parents will choose workplace child care; some will prefer neighborhood in-home care, especially for school age children. Employers should make available to their employees lists of appropriately licensed day care homes in their neighborhood. **Any** employer involvement in child care is better than a laissez-faire attitude; it improves employee morale and attracts and retains better workers.

The need is also obvious for extended day care in all school districts for older children no longer eligible for other types of child care. The era of latchkey kids must come to an end.

I have described models of employer-assisted child care that actually exist in other countries today and in some intelligent and caring businesses in America. Better choices for families are possible and would enhance the economy, not destroy it. However, these choices will not be created until our country makes its children a top priority. Child care should be considered a joint responsibility of parents and state, not just a woman's issue to be ignored. Until our attitudes change, nothing else will, and our society will eventually pay the price.



## Looking Through the Lenses of Gender:

### A Profile of Women Physicians in the United States

Scheduled to speak at the Women in Medicine's annual Meeting in Beaver Creek is Gwen Barley, PhD, who will discuss results from her dissertation research from the perspective of the current literature and discourse on women in medicine.

Dr. Barley serves on the University of Colorado School of Medicine Admissions Committee and the Committee on the Status of Women. She is the course director for Primary Care I, II, and III and on the faculty as an Assistant Professor.

The Women in Medicine Section meets twice yearly during the CMS Annual and Interim Meetings. This year's meeting is scheduled for Friday, September, 9th at 6:30 pm at the Hyatt Regency in Beaver Creek. It follows the exhibitors reception. Dessert will be served. There is no charge for this meeting, but reservations are appreciated. If you plan to attend, please contact Marilyn Barton at 930-0407 in the Denver area or 1-800-654-5653 elsewhere in the state. Non CMS members are welcome. Call the CMS offices for more information.



## Steamboat Springs Hospital commended for news media cooperation

**The Colorado-Wyoming Chief of Bureau for Associated Press** commended the staff of Routt County Memorial Hospital in Steamboat Springs for the "extreme cooperation with the news media during and after the explosion last February."

Bureau Chief Joe McGowan, Jr., a participating member of the Colorado Code of Cooperation Committee, asked that the Committee go on record in this matter. McGowan said: "It was a trying time for the hospital, but our experience at the Associated Press was that they were helpful, professional and accurate in the information they provided, and in a timely fashion".

McGowan went on to say "The hospital's cooperation with the news media was made possible by Christine McKelvie, director of Public Relations; Keith Lightfoot, director of Human Resources and Associate Administrator, and; Cathy Justice, Human Resources Assistant." McGowan added that the willingness of the Steamboat Springs hospital personnel stands in marked contrast to similar situations with other hospitals in mountain communities following other disasters.

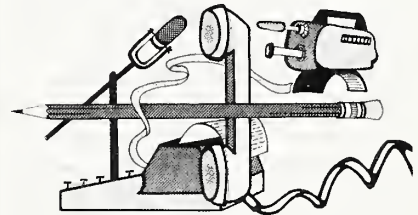
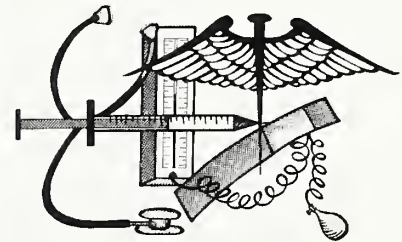
The Colorado Code of Cooperation Committee, established by the CMS Board of Directors in 1948, brings together representatives from physician, hospital and news media interests. The Code of Cooperation Committee also has a grievance process if there are specific questions or allegations posed by any of the representatives. No such grievance has been made since 1985.

At its annual meeting in May, 1994, the Committee elected Bill Scanlon, writer for the Rocky Mountain News, as 1994-95 Chairman. The chair is rotated among the three principals.

The 1994 Annual Meeting dealt with reporting issues, including medical ethics relating to organ transplants and persons admitted for treatment of mental illness. A new question was proposed for consideration: "protection of confidentiality and electronic transfer of healthcare data".

Peg O'Keefe, Vice President of the Colorado Hospital Association, reported on the "Colorado Health Electronic Data Interchange Advisory Board" created by the legislature in 1993. This group advises the state insurance commissioner on electronic data transfer. She also reviewed the "Colorado Health Management Information System" task force in which the Colorado Medical Society participates and chaired by Joan Offutt of U. S. West. Ms. Offutt was formerly associated with the Colorado Health Data Commission.

This group is studying a long-range plan which would link medical records and clinical interactive capabilities. All of the suggested use of electronics imposes increased responsibilities on all parties to strive to build safeguards for patient confidentiality. The discussion included reference to the CMS Medical Informatics Committee chaired by Dr. George Thomasson of Copic Insurance Company Risk Management.







## HEALTH DEPARTMENT

Patricia A. Nolan, MD, MPH  
Executive Director,

Colorado Department of Public Health and Environment



Tobacco use results in over 4,000 premature deaths in Colorado each year (20% of all deaths), \$750 million in excess health care and related costs and untold cases of disability due to heart disease, lung cancer, asthma, chronic bronchitis, emphysema, and chronic obstructive lung disease, etc. Colorado citizens expect their health department to continue working to reduce this most important health risk.

Recent allegations of tobacco lobbyists in Colorado have charged that the Colorado Department of Public Health and Environment and other public health agencies have been illegally working on a campaign to raise the state tobacco tax. It is imperative that I respond to these unsupported charges and affirm my commitment to educating Colorado citizens about the health effects of tobacco use and strategies that are effective in reducing its consumption.

Lawyers for the tobacco industry have spent hours combing through our files, and have received in excess of 4,000 pages of documents. They have found no evidence that we have acted improperly. So now they are left no recourse but to conclude that we are "trying to hide something."

Staff of my department have been and will continue to be, scrupulous in complying with Colorado laws prohibiting the use of public funds to influence issues before the electorate. Colorado statute also says that we have a *duty* "to establish and operate programs... promoting, protecting and maintaining the public's health be preventing,

delaying or detecting the onset of environmental and chronic disease."

Public health education programs have become immensely more sophisticated in their approach to reducing tobacco use. It is well recognized that simply offering smoking cessation classes and providing education opportunities in our schools and communities are not by themselves effective. A community and social environment must be created where those people who continue to smoke are encouraged and supported in their efforts to quit and those who are contemplating or experimenting with tobacco use are discouraged.

Hundreds of Colorado businesses have enacted smoke free worksite policies and requested health insurance premiums that offer discounts for nonsmoking employees. The Colorado General Assembly enacted a law in 1994 that requires schools to be tobacco free.

Thirty six Colorado communities have enacted ordinances to create smoke free public places. These policies and laws and many others have created a social environment that has led to dramatic reductions in tobacco use in our state and nation.

The tobacco industry will continue to characterize actions by my department as efforts to support the Colorado tobacco tax initiative. These companies are desperate to deflect attention from themselves and the many controversies that are choking them. In recent months they have been besieged by:

- allegations that they intentionally manipulate nicotine content in cigarettes to cause addiction in

smokers;

- pending actions by the Occupational Safety and Health Administration to regulate smoking in the work place;

- Congressional action to make it more difficult for children to purchase cigarettes and spit tobacco; and

- the public image created by tobacco industry executives denial (this time before Congress) that smoking causes lung cancer.

Price increases, as is proposed in Colorado, have been shown to be a particularly effective means of reducing demand among those who are considering tobacco use, and an effective means of reducing consumption among experienced smokers. For example, a 1988 25 cent increase in tobacco taxes in California resulted in a 27% reduction in consumption by 1993. Similar declines in smoking have also been observed in Canada and more recently in Massachusetts.

It is our expectation that, despite our adherence to the law, the tobacco industry will continue to object to our tobacco use prevention *educational messages* and continue to cry "foul".

Educating the public about the risks of tobacco use among children and adolescents, promoting smoking cessation, working for clean indoor air, advocating for appropriate public policy regarding tobacco — these are among our most important responsibilities. We will not be intimidated by the tobacco industry and shrink from our duties.



Edie K. Register, Director

## Unlisted Procedure, \_ \_ \_ 99, The Dump Code and Related Coding Issues

Our Medicare claims processors call these dump codes because physicians and billing persons tend to dump into these codes those parts of a procedure that don't seem to fit into any of the other available codes. The use of these codes is legitimate if, in fact, there is no other combination of CPT codes that adequately describe your procedure. But, legitimate or not, the \_ \_ \_ 99 codes always entail four things; you will need to send a copy of the op note, this most often eliminates electronic billing, we must review the claim and op note, and your payment is delayed.

When the procedure is particularly complex, the RN reviewers will ask me to address the \_ \_ \_ 99 code. In more than 75% of the cases, I am able to find a satisfactory combination of codes. My first recommendation is this; spend a little time with your CPT manual. You may well be able to avoid a dump code.

My second recommendation is this. If someone else picks the codes, then you should, when you dictate the name of the procedure at the top of the op note, use language that matches the language in the CPT manual. If that heading is unclear, your billing person may choose to use a dump code which sets into motion those things mentioned above.

Or, that billing person may choose, not a dump code, but the wrong code which may lead to an underpayment, or if the wrong code

pays more than the right code and is used frequently, the carrier may raise the question of fraud.

My third recommendation is that you check your claims frequently, to be sure that your billing person is picking the right code. I recently reviewed a claim from a plastic surgeon who did a complex open repair of a forearm fracture. The op note said "reduction of fracture..." and the claim came in with a code for a closed reduction. Further, the claim included a dump code, presumably for a second procedure which was, in fact, part of the open reduction. I am presuming that a billing clerk picked these codes - both wrong. This error could have been avoided if the surgeon had been more precise when he dictated his op note or if the surgeon selected the CPT codes himself.

Many times, of course, your procedure is unlisted and a dump code is the right code. On the claim, please append a word or two to the dump code that will direct our RN reviewer to the appropriate part of the op note. This will speed up the process of identifying the part of the procedure related to the dump code and its proper payment.

Finally, if your claim goes to the post pay department for review and appeal, please review the claim. You might find that the CPT codes used were not correct and by correcting them you will often resolve conflict between your claim and our payment.

**Grant Steffen, MD**  
*Medical Director,  
Medicare Part B  
Colorado Medicare  
Carrier*



## D

## estination: Bangladesh

by **Drs. Eugene L. Weston and James A. Shane**  
Lakewood, Colorado



Dr. Weston (l), Sashire, the medical assistant, and Dr. Shane.

Bangladesh is a small country (55,000 square miles, an area the size of Colorado/Wyoming) with 130 million people (60 million in 1960). It is situated in east India (old East

Pakistan). Unfortunately, It is poverty stricken with few cash crops and situated in the flood plain of three major rivers with much of the land only twenty to thirty feet above sea level. With tropical heat, monsoons and floods, it is a breeding ground for a multitude of tropical diseases.

There is no national welfare or health system. Most of the cities are without central water or sewer facilities. The stench of decay is everywhere accompanied by the smog and multiple dung/wood fires. Yet, the jungle is beautiful with lush vegetation, a variety of bird species, tigers, elephants, jackals, pythons, adders, kraits and cobras. The Bengali people are a handsome group, very intelligent and appreciative.

It is this area of the world to which **Dr. Viggo (Vic) Olsen** and his wife, Joan, journeyed in 1962. A missionary's daughter had died of a bowel obstruction because of no surgical facilities in the country. Dr. Olsen felt called to establish a hospital where there had been no previous western medical care. Thirty years later, Memorial Christian Hospital enjoys an outstanding reputation. Of interest, Dr. Olsen was a classmate of **Dr. Joe Kovarik** at the University of Nebraska. He com-

pleted his surgical residency at the Medical College of Wisconsin and Milwaukee County Hospital.

**Dr. Jim Shane** (also from the University of Nebraska) worked with Dr. Olsen in Bangladesh in 1981 and again in 1989. Dr. Olsen fractured his hip this past year and is presently unable to do surgery; hearing this, **Dr. Gene Weston** volunteered to accompany Dr. Shane for the month of April, to carry the huge load of general surgery.

The medical and surgical illnesses were as diverse and different from Lutheran and St. Anthony Hospitals as anyone could imagine. On the wards were tetanus, typhoid, falciparum malaria, many of these patients unconscious with cerebral-type malaria, typhus, shigellosis, polio, cholera and all types of worm infestations. Multiple injuries, burns and tumors as well as huge hernias and many obstetrical complications made up the surgical problems. One really had to do "general" surgery; machete wounds with depressed skull fractures and brain injuries, multiple amputations, supracondylar fractures as well as hip fractures, gastric cancer with obstruction, intussusceptions, kidney, ureteral and urethral injuries, Cesarean sections, emergency hysterectomies for ruptured uteri (after the village midwives finished with their ministrations), skin grafting, vascular injuries, goiters and quadriplegic and paraplegic injuries from elephant attacks. We were happy to have fifty-eight of sixty successful surgeries, with only two septic deaths due to a ruptured uterus and a ten-day-old perforated ulcer. Post operative

*This article has been reprinted, in part, from the Lutheran Medical Center publication, "ROUNDS".*

## Destination: Bangladesh

(Continued)

wound infections are the rule due to the Severe malnutrition and advanced diseases but we were gratified to have NONE!

The World Health Organization's Oral Rehydrating Solution (ORS) was extensively used in place of IVs. X-ray and EKG support was minimal. We were unable to get a serum potassium for the month-of April, Chloromycetin, (a wonderful drug!) Flagyl, gentamicin, tetracycline and ampicillin were available. We took along Cipro and used it extensively. Anesthetics consisted of spinal, local, extensive use of ketamine and occasional general anesthesia.

The Christian hospital staff is extremely dedicated to the medical work as well as to teaching the gospel. The population of Bangladesh is ninety-five percent Muslim, four percent Hindu and less than one percent Christian. The missionaries have now translated nearly the entire Bible to the Bengali language and portions of scripture into multiple dialects. Bengali Nationals are being trained to assume leadership in the hospital. Dr. Weston told **Colorado Medicine** "My surgical assistant had the equivalent of a high school education and had been at the hospital for ten years. He assisted me in most surgery, gave general anesthesia and he, himself, did most of the hernia surgery as well as skin grafting and repair of cleft lips and cleft palates".

Additional information regarding Memorial Christian Hospital may be found in either of the two best-sellers Dr. Olsen has written: *Daktar I* and *Daktar II*. The Hospital welcomes short-term medical volunteers.

*Ed. Note: Dr. Eugene Weston, a former member of the CMS Board of Directors, and currently a member of the 9Health Fair Advisory Board, is retired from full time practice and now does a great deal of volunteer work. He worked in Bangladesh from April 4 to May 5, 1994.*

## "Women's Health Initiative" a new program and lecture series by KRMA-TV Channel 6



Six Health  
Issues of  
Concern to  
Every Woman

**Public Television Station KRMA-TV** in Denver has commenced a large health undertaking consisting of eight separate programs dealing with women's major health issues, including "Her Health Matters" addressing smoking, heart disease, domestic violence, breast cancer, clinical depression and osteoporosis.

In addition, Channel Six will be teleconferencing with rural areas allowing interaction between various rural areas and medical experts in Channel Six studios.

The station will also be producing and broadcasting local and national 60 second information spots concerning facts and health tips for women.

There will be three lectures, including the first two which have been announced: Dr. Judith Reichman, the host of "Straight Talk on Menopause" and Juliet Wittman, author of "Breast Cancer Journal: A Century of Petals"

The program and lecture series, reinforced by the 60 second women's health informationals, will be in addition to a brochure, "Six Health Issues For Every Woman," which contains printed information on all the subjects discussed in the series, and the publication of a guide to national and local resources of women's health and wellness.

This is all a part of a national campaign, "Women's Health 1994 on Public Television".

Colorado Medical Society was able to assist in this campaign by helping KRMA-TV contact our physician members, notifying them of the lectures and the printed information to distribute to their patients.

If you wish further information about the programs, the lectures, or the printed information, contact the Communications Department of CMS at 303/779-5455 or 1-800/654-5653. Or, you can contact KRMA-TV at 303/892-6666





## HEALTH CARE POLICY

### Cost, Mortality, Utilization

### – all tied together in Health Data Commission Report

by Ellen J. Stein, Director  
Division of Health Care Policy  
Colorado Medical Society

#### There will be questions!

##### **\* Recommended Questions for Physicians:**

- Are you familiar with the Data Commission's 1992 Hospital Outcomes Report? How do you interpret the Report's findings for treatment of (disease) at (hospital)?
- How many patients did you treat for (disease) last year? How does this compare with the number of cases treated by other local doctors in your specialty?
- How do the mortality figures for your practice compare with those of other specialists for this particular procedure? (Note: Physicians may not have exact figures, but should have an idea of the range for major categories. Look for awareness, rather than absolute numbers.)

#### **Colorado Health Data Commission Releases Report**

On August 2, 1994, the Colorado Health Data Commission released a new report, Colorado Hospital Outcomes: Mortality, Length of Stay and Charges for Cardiovascular and Other Conditions, 1992.

Without doubt, you, Doctor, will be questioned about this report.

If you have not seen the report, get a copy and read it. Be able to answer your patients questions and those of others. Work with your colleagues to understand the data and use it to improve the quality and cost effectiveness of the health care provided in Colorado.

The report used Medis-Groups to adjust mortality, length of stay and charges for severity of illness at admission. Severity adjustment uses a large number of key clinical findings abstracted from patient records to estimate the probability of a certain outcome (death, length of stay, average charge) while in the hospital according to the patient's condition at admission.

#### **What the report found:**

- Colorado hospitals compare favorably to hospitals in other regions of the country on inpatient mortality and length of stay.
- Average charges in Colorado are about 10% higher than hospital charges in other regions. It was

suggested that this might be due, in part, to the impact of managed care contracts in our state.

- Large Colorado hospitals varied significantly in mortality, length of stay and charges for patients with the same condition and similar severity of illness. The report noted that for most of the conditions studied, number of deaths was not significantly different than expected for the 24 large hospitals studied. However, there were some hospitals with more deaths than expected and others with fewer deaths than expected.

- The report also shows large differences in average length of stay and average charges after adjustment for severity of illness at admission.

- Prices varied markedly after adjustment for severity of illness at admission.

#### **What are the values and limitations of the report?**

**The report is the first step in using severity-adjusted data in Colorado.** It enables health providers and patients to compare charges, length of stay, and mortality rates by hospital, taking into consideration how ill the average patient was at the time of hospital admission. The report is therefore able to reflect the fact that some hospitals regularly admit seriously ill patients and are more likely to have higher average patient stays, mortality rates and charges than those that typically treat fewer seriously ill patients.



***"Colorado Hospital Outcomes:  
Mortality, Length of Stay and Charges for  
Cardiovascular and Other Conditions . . ."***

Comparative data is valuable to physicians and is an important tool for use internally to improve the quality of care and outcomes for patients. Similar data has been shown to improve mortality outcomes and charges in hospitals in Cincinnati, New York State, Pennsylvania and Cleveland. Public data has not, however, changed patients' choices of hospitals. **Hence, this data is of most importance to providers, who need to carefully review it and learn from it. The patient will reap the benefits.**

The report contains a number of cautions regarding interpretation of the data. The report examines some measures of quality, however, mortality is by no means the measure of quality of care. Other patient outcomes such as quality of life, patient function or patient satisfaction are not reviewed. Additionally, the report does not consider some patient-related information that may influence outcomes (i.e. preexisting, underlying illness; socioeconomic factors; patient compliance; etc.). Also, as providers of health care are continually looking for ways to increase quality and decrease cost, findings from 1992 may have changed. With regard to charges, what was collected represents the "sticker price". It is difficult to compare the dollars hospitals actually collect

**What this means:**

This publication should be used to raise questions, not draw conclusions.

The report is an important first step and physicians must recognize its value for use in improving the quality and cost-effectiveness of care. The data can be useful as a benchmark by which hospitals and physicians can begin to evaluate quality of care.

The Rocky Mountain Heart Consortium published a *Consumer Guide and Commentary* to the Data Commission report. Both the Commission and the Consortium recommended that purchasers of health care use the report to ask questions of their health care providers. The Consortium publication states that "The greatest value of the report may well be that it encourages consumers to ask further questions about the report's findings" and recommends specific **Questions for Physicians\*** (See box on preceding page).

***The 1992 Hospital  
Outcomes Report is  
available through the  
Colorado Health Data  
Commission, 1313  
Sherman Street, Rm 521,  
Denver, CO 80203  
or phone:  
303-866-4908;  
fax: 303-866-2803.***



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# The 1994 Constituent Skills Workshop

October 21, 1994—CMS Board Room

*You've already invested a minimum of 4,380 days of your life to learning the healing arts. Can you afford not to invest a half day in the political arts in order to avoid having your practice run by lawyers and bureaucrats?*

## Are you willing to let **others** decide the future of health care?

Health Insurance reform is far more than just another political issue. It will determine how you will practice medicine in the future. And that's just number one on a long list of health-related political issues.

## Who can best represent **your** interests?

You, the individual physician, are often the most effective representative of the cause of medicine in the political arena. You have the specialized knowledge and ability to get your voice heard — if you are willing to act.

## I voted — Isn't that enough?

Grassroots activism really gets the attention of lawmakers. And who isn't willing to listen when his or her own personal physician calls with an opinion?

Many people are frustrated with the government. You are the one who can do something about it. This workshop will teach you to write an articulate letter that will make your representative sit up and take notice. You'll be on the list of people called for an opinion when health care issues come up.

## AGENDA

- 8:30 am Continental Breakfast
- 9:00 am Welcome  
*Richard Allen, MD*  
Introductions  
*Michelle Johnson, AMPAC*
- 9:15 am The Political Environment for Medicine — Why Grassroots Political Action is Necessary  
*Mike Dunn, President, Michael Dunn & Associates*
- 10:00 am Understanding the Legislative Process
- 10:45 am Break
- 11:00 am Becoming a Player in the Legislative Process
- Noon Lunch

## Space is Limited! Register Early!

Name \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Please fill out this form, place it in an envelope with your check for \$25, and mail it to:  
Government Relations—Colorado Medical Society  
PO Box 17550  
Denver CO 80217-0550

For more information call 303-779-5455 or 1-800-654-5653



## Noted Denver Ophthalmologist Dies



**Frank A. Perreten, MD** of Denver died recently of a massive heart attack. He was 67 and had been a member of the Colorado Medical Society since 1960.

Dr. Perreten had been born in Boulder, but attended grade school, Junior High and High School in Denver. He received his Bachelor of Arts from the University of Colorado. He received his Doctorate of Medicine from the University of Pennsylvania, did a rotating internship at St. Luke's and Denver General hospitals, then served as a resident at the Massachusetts Eye and Ear Infirmary of Harvard University in Boston for three years.

Having served as a member of the Colorado Medical Political Action Committee for many years, Dr. Perreten was on the Board of Directors when he died. He was active in numerous civic affairs and was a professor at the University of Colorado School of Medicine.

## In Memory

*We have received information on the deaths of the following physicians since the last time we published such a list.*

Fred Tepley, MD, of Denver, died 1/4/94

Edgar Barber, MD, of Denver, died 1/20/94

Charles W. McClellan, MD, of Colorado Springs, died 1/21/94

Harry V. Unfug, MD, of Fort Collins, died 1/24/93

Charles G. Freed, MD, of Denver, died 2/94

Harry D. Jones, MD, of Longmont, died 2/4/93

Harvey M. Tupper, MD, of Grand Junction, died 2/5/93

Ernest P. Elzi, MD, of Denver, died 2/6/94

H. M. Vanderschouw, MD, of Leadville, died 2/12/93

Frank I. Nicks, died Jr., MD, of Colorado Springs, died 2/12/93

Margaret E. Westerlund, MD, of Denver, died 2/15/94

J. William O'Connor, MD, of Englewood, died 2/16/93

John V. Ambler, MD, of Denver, died 2/20/92

George DeTar, MD, of Colorado Springs, died 2/25/93

Robert W. Virtue, MD, of Denver, died 3/94

Charles M. Abernathy, died Jr., MD, of Denver and Steamboat Springs, died 3/94

H. Sol Cersonsky, MD, of Denver, died 4/11/94

Clarence J. Roberts, MD, of Thornton, died 5/7/93

Ruth J. Raattama Fisher, MD, of Denver, died 5/19/94

William Condon, MD, of Denver, died 6/1/94

William F. Peacock, MD, of Littleton, died 6/18/94

Mitchell B Rider, MD, of Denver, died 6/22/93

Edward S. Miller, MD, of Denver, died 6/23/94

Frank A. Perreten, MD, of Denver, died 7/94

Franklin L. Bowling, MD, of Englewood, died 7/13/93

Roger S. Mitchell, MD, of Denver, died 9/1/93

Stephen C. Scott, MD, of Denver, died 10/2/93

Roger Howlett, MD, of Arvada, died 10/31/93

Sydney Foster, MD, of Orcas, died WA, died 11/20/93



# TELL YOUR PATIENTS THEIR CHOLESTEROL NUMBER... BEFORE THEY ASK.

Reducing high blood cholesterol reduces the risk of heart disease. That's why we're telling Americans—through a national public service advertising campaign—to know their cholesterol number. Your patients may soon be asking you for their number and what it means.

And when they do, we can help. The National Cholesterol Education Program, administered by the National Heart, Lung, and Blood Institute, has developed adult treatment guidelines to help you identify high-risk patients and use the appropriate diet and/or drug therapy for those with elevated cholesterol levels.

Help your patients reduce their risk of heart disease. For a free copy of the *Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults*, complete the form below.

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mail to: Cholesterol Adult Treatment Guidelines  
National Cholesterol Education Program  
National Heart, Lung, and Blood Institute  
C-200-GA  
Bethesda, MD 20892



**NATIONAL CHOLESTEROL EDUCATION PROGRAM**  
**NATIONAL HEART, LUNG, AND BLOOD INSTITUTE**

National Institutes of Health • Public Health Service • U.S. Department of Health and Human Services



## "Dr. MOM" heads tobacco tax initiative

"Dr. MOM," well-known in television and literary circles, has taken on and met a new challenge: to place an initiated referendum on the November ballot to authorize an additional 50 cent tax on every pack of cigarettes sold in Colorado.

Maryanne Niefert, M.D., well-known Denver Pediatrician and celebrity author "Doctor MOM", headed a campaign (by voluntary health agencies and the Colorado Health Department) in gathering 102,615 signatures. They were delivered to the Secretary of State on August 4th, meeting the state deadline. The law requires a 30-day check period, during which all signatures turned in will be checked until the required number of 49,279 valid signatures is reached; however, that wasn't necessary. In less than two weeks, Secretary of State Natalie Meyer announced that the tax question will be on the November 1994 ballot. She said a random check of the pryiyiond showed there were nearly 76,000 valid signatures, far in excess of the minimum number needed.

**"Tax Cigarettes To Protect Children"** was the slogan, brought into action to rally the many health leaders and statewide groups. This tax will, if approved, generate an estimated \$130 million in all new dollars to be divided between medical care of the indigent, health education against tobacco use, particularly among those of school age, related community health programs and for further research.

Frank "Pancho" Hays, lobbyist and spokesperson for the tobacco industry, told the Rocky Mountain News that "It will be war". Hays said this initiative was no more than an attempt by "these

bureauacrats to get their hands on \$130 million".

## Colorado Blue Cross/Blue Shield bows out as Part B Medicare intermediary

Blue Cross/Blue Shield of Colorado has decided not to seek renewal of its contract as Medicare Part B carrier for the state of Colorado, the federal Health Care Financing Administration announced July 26th.

According to HCFA Administrator, Bruce C. Vladeck, the company cited financial reasons for its decision.

"We are pleased that Colorado Blue Cross/Blue Shield has offered full cooperation to assure a smooth transition to a new contractor", Vladeck said.

"Medicare beneficiaries and providers in Colorado can be sure there will be no interruption of service. HCFA has extensive experience in making these changes efficiently", he said.

Vladeck announced that North Dakota Blue Cross and Blue Shield, which "has a strong record of customer service and reliability in claims processing", will assume the Part B contract for Colorado.

HCFA will require that the new contractor establish and maintain a local presence in Colorado and consider for employment the personnel currently serving in the Medicare Part B staff of Colorado BC/BS.

Medicare Part B contractors process claims from physicians and other medical professionals, screen claims for errors, fraud and abuse, and are responsible for communications with beneficiaries and health care professionals who bill Medicare.

HCFA, which administers the Medicare and Medicaid programs, helps pay the medical bills of 67 mil-

lion Americans. HCFA's fiscal year 1994 budget amounts to nearly \$250 billion.

## Going Beyond the Call

We were recently informed of an interesting concept which may interest some of our many philanthropic physician-members. The information comes from the Hospice of Metro Denver. It seems that Dr. Nicholas Di Bella, a longtime CMS member has a practice of remembering his patients with a donation to the hospice.

"Dr. Di Bella's dedication extends beyond routine office visits," says Denise Fisher of the Hospice, "His gifts serve to enhance the comfort and care of other hospice patients and families."

Though Dr. Di Bella might be embarrassed to hear it, Ms. Fisher says he is "an outstanding example of a physician who is genuinely dedicated to his practice of hematology and oncology." and "Dr. Di Bella is not only genuinely committed to his practice, but is a true humanitarian who is dedicated to his patients and their families."

We have long noticed that Colorado's physicians are uncommonly dedicated to the welfare of their patients and to the health and well-being of society at large. This is another example of how concerned professionals go beyond what is required of them to benefit those in need. Perhaps other physicians would like to emulate Dr. Di Bella's excellent example.

## Correction

We reported in the July issue of *Colorado Medicine*, page 252, that the Denver Diabetes Center is conducting a study of Type I Diabetes Mellitus patients on hemodialysis. The correct telephone number to contact Helena Chung-Hawks, research coordinator, is 333-4441.





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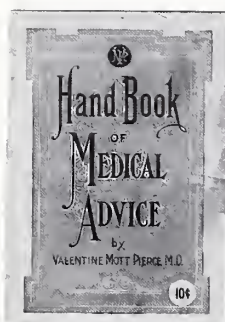
Write for **free information** on patient medicine counseling.



NCPIE  
666 Eleventh Street, NW  
Suite 810  
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Or FAX:  
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## RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

### Everything was simpler!



**INVALIDS' HOTEL AND SURGICAL INSTITUTE.**  
No. 663 Main Street, Buffalo, New York.

**A MODEL SANITARIUM AND SURGICAL INSTITUTE.**

*The Invalids' Hotel is not a Hospital, but a Pleasant Residential Home, organized with*

**A FULL STAFF OF PHYSICIANS AND SURGEONS,**  
**FOR THE TREATMENT OF ALL CHRONIC DISEASES.**

We have not the space to speak individually of the large number of professional gentlemen comprising the Faculty of this old and world-famed Institution, but will say that among them are those whose long connection with the Invalids' Hotel and Surgical Institute has rendered them experts in their several specialties. Several of them had previously distinguished themselves in private practice, had held important professorships in Medical Colleges, and had filled responsible positions in both military and civil hospitals.

**VISIT OUR SANITARIUM**

If in need of remedial treatment for any form of chronic ailment, whether requiring medical or surgical means for its relief, if you can not come, send us a full and complete history of your case, or write for one of our

question blanks. It is well also to send a sample of urine for our chemist's examination. For while, in many cases, no light may be thrown upon the nature of an ailment by such examination, yet, in diabetes, Bright's disease and some other affections, valuable knowledge is thereby gained for the sufferer's benefit. We make no charge for consultation by mail.

Write and describe your symptoms, sign your name very plainly, giving also the name of your Profession, County and State and our terms for treatment and all particulars will be sent you.

Address all letters to  
**INVALIDS' HOTEL, OF**  
**World's Dispensary Medical Association,**  
663 MAIN ST., BUFFALO, N. Y.

### Can we ever go back?

In the advertisement (left) for the "Invalid's Hotel and Surgical Institute", (circa 1917-18) as the ad states, "The Invalid's Hotel is not a Hospital, but a Pleasant Remedial Home, organized with a full staff of physicians and surgeons for the treatment of all chronic diseases".

The ad goes on "Visit our sanitarium if in need of remedial treatment for any form of chronic ailment, whether requiring medical or surgical means for its relief. If you can not come, send us a full and complete history of your case or write for one of our question blanks. It is well also to send a sample of urine for our chemist's examination, for while, in many cases, no light may be thrown upon the nature of an ailment by such examination, yet, in diabetes, Bright's disease and some other affections, valuable knowledge is thereby gained for the sufferer's benefit. We make no charge for consultation by mail".

This advertisement was in a booklet published by Valentine Mott Pierce, M.D., of the World's Dispensary Medical Association, 663 Main Street, Buffalo, N.Y.

The "Handbook of Medical Advice" contains a 14-page collection of "home remedies", from Acne to Whooping Cough, even including the following home treatment: "**St. Vitus' Dance**, or Chorea, is a germ disease, due to the same streptococcus which produces rheumatism, tonsillitis in children. It usually occurs between five and eighteen years of age. The child makes restless motions of the hands, face or feet, is 'fidgety.' Should not be treated with medicines. The child should be

taken out of school, and in severe cases kept quiet in bed. A child will usually outgrow the trouble."

Actually, to me, a non-physician, that sounds like pretty good "free" advice for its era.

The handbook also contains seven pages of advertisements for Dr. Pierce's medicines, herbal extracts, and Dr. Pierce's own brand of "editorial advertising", such as the appeal to women by the illustrated editorial (below) for **Dr. Pierce's Favorite Prescription**.



But out of this kind of medicine grew the best system of health care in the world.. However, even as you read this, Congress is about to take this system apart . . . and hopes to reassemble it . . . in its political (not medical) effort to reach an additional 10% of the total population with what we call "public access".

As CMS President, Dr. Wm. Bailey said in the August "President's Letter", this, without question is "**the greatest social experiment in our history**". It is certainly not without peril. Can we ever get back what has been or once was? That's the peril!

Yes, in a bygone era, health care, like everything else, was a lot simpler!



# COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

October, 1994

Volume 91, Number 10

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**TO: Every member of the  
Colorado Medical Society**

Regarding RES 76-A ... your Colorado Network Task Force Feasibility Study

**See Page 354**

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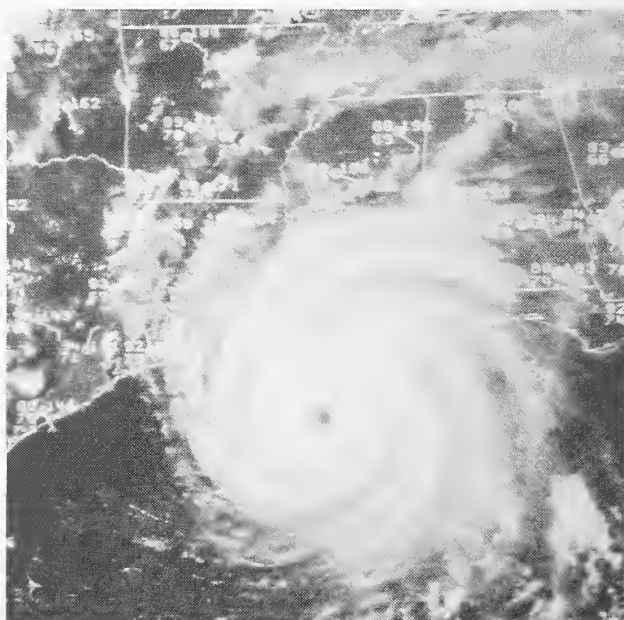


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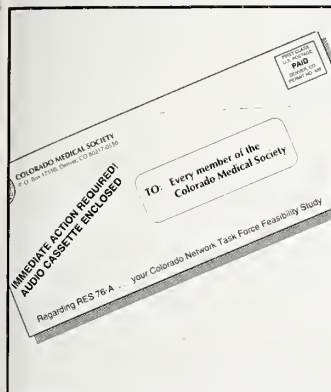
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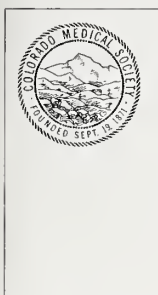
October, 1994

Volume 91, Number 10



## Cover Story

The cassette's in the mail. By now you should have received it, and it contains information vital to the future of health care in Colorado.



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David C. Martz, MD  
President, 1994-1995

Inaugural address (unabridged) of CMS President David C. Martz, M.D.

**DREAMS HAPPEN!** How many times have you seen this bumper sticker on the car ahead of you, and wondered what particular Dream-Come-True had prompted that driver's declaration?

- A perfect marriage?
- A child accepted to Harvard?
- A promotion to District Manager?
- A treasured baby after years of infertility?

All of us have witnessed dreams come true, and to one degree or another we have EXPERIENCED dreams come true. The mere fact that we are here tonight as physician families implies fulfillment of hopes far beyond the aspirations of most.

Scientifically, most of us have shared many of the miracles of the past 50 GOLDEN YEARS of medicine:

The advent of penicillin in the early '40s, followed now by scores of antibiotics, has dramatically reduced the premature deaths of otherwise healthy children and young adults by bacterial infections.

Polio, killer andcrippler of my grade school classmates, is now a rarity due to the discovery of effective vaccines.

Open heart surgery, pioneered in the '50s and frequently fatal in the medical schools of the early '60s, is now an every day occurrence in community hospitals throughout the nation.

Childhood leukemia, disseminated Hodgkins Disease, and widespread testicular cancer are but a few of the universally lethal malignancies of 30 years ago now routinely cured with modern che-

motherapy.

The list goes on and on in virtually every specialty: cataract surgery with lens implantation; survival of low birth-weight infants; artificial joint replacement; sophisticated imaging with CT and MR scanners; laparoscopic laser surgery through every orifice and body cavity.

How fortunate we are to live these dreams not even comprehensible to prior generations!

For most of us the opportunity to ENTER the world of medicine has also been a culmination of dream realizations. Perhaps you--like I--came from modest origins: a small town heritage in a family of limited financial resources, high moral values, a strong work ethic, intense altruism, and a devotion to education as well as community responsibility. Of necessity academic over-achievers, we graduated in the upper percentiles of our High School class, usually with multifaceted interest from sports to music or drama and student government.

On to college, often financed by scholarships and part-time employment, we faced the terror of knowing that even a "B" was a failing grade if we hoped to be among the fraction of elite applicants accepted into medical school. Truly, the "Congratulations on your acceptance" letter was TOP-DREAM-TO-DATE, surpassed only by the moment of doctoral graduation four-or-so years later. Internship and residency matching hurdles came next, and it wasn't until 9 - 15 years after high school completion that we finally entered our World of Dreams--the

## DREAMS HAPPEN!

*"...you may wish to review **our** responsibility in bringing sanity back to Health Care."*



## Practice of Medicine!

Although we are recently beset with a growing list of frustrations and uncertainties, by the standards of many other professionals, our lives reflect an enviable achievement. Compared to musicians, engineers, academicians, ministers and accountants, we have enjoyed remarkable job stability and remuneration. Certainly other professions such as law, dentistry, and business yield comparable earning potential, and there are those who are far more affluent than any of us; yet it is not inappropriate for physicians to expect incomes commensurate with their training, skills, responsibilities, stress and hours.

But dreams dare not be dollar-driven. Our lives have other special dimensions: Much of what we do professionally is mysterious--or even "magic"--to those whom we serve; We enjoy the ever-expanding frontiers of knowledge and technology almost as it happens; Our days are colored with unpredictable variety and emotional challenges.

We share intimacies with our clientele unknown in other fields—personal confidentialities, fears, pain and losses as well as courageous physical and spiritual conquests.

And for many years we have had the luxury of remarkable INDEPENDENCE. We have had far more latitude of career choices than most, involving where, when, with whom, what limits, how often, and why. "To be your own boss" was in fact a decisive attraction to medicine for many of us in the first place, and the responsibility of being "IN CONTROL" is innate to both our training and the personality compatible with it.

Yes, in these--and many other--ways, our lives have been a series of Dreams Come True: a special calling with special rewards which we cherish deeply . . . and rightly so!

But if dreams can **happen**, they can also **fade**. Witness last Sunday's Bronco lead of 17-0 and 24-6 deteriorating to a 37-34 fiasco! On a more serious note, homes burn

down, marriages go sour, and children become estranged. Even more cogently, outside forces can—and have—entered into "our world" of medicine and changed it forever.

As you all know so well, we are now faced with control being wrested away from us by intruders such as hospital administrators, managed care MBA'S and clerks, as well as national and state legislators. Administrative hassle, shrinkage of market share by arbitrary HMO disaffiliation notification, long-term patients forced to change doctors by employers insurance panels, probable income reduction, contractual gobbledy-gook, and hospitals out to buy and salary us are but a few of the threats we face.

Suddenly thrust through the Looking Glass into an Alice-in-Wonderland nightmare, we do not understand the new rules to the game: in the past it was our individual reputation for skills and style that attracted our patient population; all of a sudden, it has been depersonalized for both patient and physician. Doctors and recipients alike fear a medical version of Russian roulette driven by statistics of uncertain validity and susceptible to capricious manipulation. For us this feels like a toboggan ride on a double diamond slope filled with skiers and trees!

Yes, dreams can not only fade—they can become NIGHTMARES. If that be the case, it's time for us to wake up and get back to REALITY!

Reality says that **no one** is better suited to make medical decisions than the doctors. It also says that doctors are in disarray, paralyzed by fear and anger, internally factious, unable or unwilling to investigate the new non-medical dimensions of health care delivery; that beyond screaming "Unfair, Unfair!" or selling out in panic to the most persuasive bidder, we have no plan of action. The applicability of these assertions may have greater or lesser merit from one physician to another.

Reality also says that change is here to stay . . . oxymoron notwithstanding. Just like Xerox, cellular telephones, video games, tele-

marketing, and FAX machines, we can't un-invent Health Care Reform.

However, we are not unique in our penchant for denial. For example:

In 1902, H. G. Wells asserted, "My imagination refuses to see any sort of submarine doing anything but suffocating crew and foundering at Sea."

In 1943, Thomas Watson (former chairman of IBM) predicted, "I think there is a world market for about FIVE computers."

In 1953, Business Week projected "With over 50 foreign cars already on sale here, the Japanese auto industry isn't likely to carve out a big slice of the U. S. market."

And, in 1946, Daryl Zanuck of 20th Century Fox confided, "TV won't be able to hold onto any market it captures after the first six months. People will soon get tired of staring at a plywood box every night!"

On a more serious note, it was Helen Keller who said "The greatest calamity of all is to have eyes and not see."

Yes, **Dreams DO happen . . . and dreams may fade**. But dreams don't JUST happen: they are the product of wisdom and work—not wishes and miracles.

In the immortal words of Martin Luther King, "I have a Dream." Remember if you can that in the 1960s when he uttered those historic words, there was no clear strategy for combating discrimination. Committed to **unification** of the factions within his community, values of undisputed legal and ethical virtue, strategic analysis of all options, and temperate methodology, he succeeded where hotter heads or meeker minds would have failed.

We began working on our dream at the planning conference at Vail in May. Entitled "**Changing Our Luck**," we spent two full days sorting out our priorities for the year ahead. The issues you said were most important included:

1. Managed Care Resource support;
2. Pro-active legislation;
3. Coalition building;
4. Membership enhancement; and
5. Improved communication.

In addition, your Health Affairs Council has developed Task Forces to focus on Rural Health Care and Youth Issues. Resolutions 51-P and 53-A outline their recommendations, and I commend them to your careful consideration.

Let me respond to your *Dream Wish List* in reverse order. Do you know that in this age of INFORMATION Superhighways we are so deluged with communication that we do not even read our mail? The Network Task Force sent out 1100 letters to our membership requesting a one-minute phone call response to indicate willingness to participate in the \$20,000 managed care survey you authorized at the Interim Meeting; do you know how many responses we got? 91! We were devastated . . . Could it be that less than 100 doctors in the whole state cared enough about their future practice options to make a simple phone call? We decided perhaps it was a matter of reading your mail, so we followed up with FAX reminders, and, sure enough, over 400 of you quickly agreed to participate. . . we simply had to **get your attention!** We have learned our lesson; this year we will work on giving you "Sound Bytes". . . headline attention-getters with details available if you wish. Since I am a novice in the world of electronics, I would be grateful for any and all suggestions you may have to implement this dream.

In regard to membership enhancement, Dr. Bailey has already initiated efforts to reach out to the un-enrolled. The entire country is struggling with this issue to the extent that the AMA has embarked on a two year study of the Federation and its organizational structure. I am your Colorado representative to that massive task force and will work diligently to triage our needs and theirs. I will consider recruitment of at least 10% of the un-involved physicians as a vital priority this year. We desperately need not only their dues, but more importantly their knowledge and unanimity.

We are already working on our legislative strategy for 1995 that will include intensive efforts to persuade

the House of Medicine to speak with one voice. I am in particular concerned about the growing schism between "gatekeepers" and "specialists", and the allegation that CMS speaks exclusively—or predominantly—for specialty interests. **This perception must be abolished**, and we must come to some common ground of equanimity between primary care and referral physicians! The observation that in time of crisis physicians circle the wagons and shoot inward must vanish, or the vultures will feed on our rotting flesh!

Only then can we move effectively to the next step—that of developing useful coalitions with other interest groups. Can you imagine the power that could be wielded if we could negotiate specific alliances not only with other providers but also with selected business and consumer interests? That is a big part of my dream.

In regard to managed care tools, Drs. McCartney and Karlin have been meeting for several months with representatives of the HMO Association. Their initial project is to negotiate new guidelines about affiliation-disaffiliation processes to minimize the mysteries of rejection, and hopefully to allow behavior modification opportunities for a physician at risk of termination. Encouraging progress has been made, and both the number of issues and participants is expected to enlarge in the months ahead.

But our key issue this weekend—and this year—is Late RES 76-A: The Network Task Force Feasibility and Assessment. As you heard in yesterday's Task Force presentation, the initial survey indicates that there is still opportunity for a physician-directed program to impact managed care in Colorado. We now need to decide exactly **how** to approach this. It is our plan to infuse the task force membership with knowledgeable representatives of existing regional IPAs, to seek a consultant capable of clarifying our options and focusing our efforts to a specific plan of attack, and to move forward quickly with a marketing feasibility study in

the next three months.

It is certainly true that this may be "Too little, Too late", or that we may find obstacles beyond our control: But if David the Shepherd Boy had left the stones in the brook, Goliath would have ruled the land! It is our hope that we can learn quickly from the good and bad experiences of our coastal colleagues and enter the learning curve higher up on its exponential arm.

We can not PROMISE success. Although as a hematologist I can not guarantee my patient with acute leukemia that chemotherapy will cure the disease, it is not unreasonable for a young adult to give it a go with a 60-80% chance of complete remission, and a 20-30% chance of cure, compared to a 100% chance of early death without treatment! **We** must decide if we are candidates for cure. . . or for Hospice!

We therefore believe you will recognize the value—no, the NECESSITY—of moving ahead with Network Feasibility this year. Although none of us would ever lay claim to being a Hero of History, it is comforting to note that even some of them had inauspicious beginnings. For example:

- Caruso's parents wanted him to be an engineer, and his teacher said he "had no voice at all and can not sing."
- Beethoven handled the violin awkwardly and preferred playing his own compositions to improving his technique; his teacher called him **hopeless** as a composer.
- Disney was fired by a newspaper editor for lack of ideas and went bankrupt six times before building Disney World.
- Albert Einstein did not speak until he was four and did not read until age seven. His teacher described him as "mentally slow, unsociable, and adrift forever in his foolish dreams".
- And finally, Tolstoy—author of *War and Peace*—flunked out of college, and was described as "both unable and unwilling to learn".

We have suffered the same accusation: "UNABLE and UNWILLING to learn" when it comes to life after managed care. My dream for



CMS is to prove not only that we CAN, but that we WILL learn to survive—no, to LIVE—in the '90s and to regain leadership in health care delivery. But YOU must believe that, too. We need not only your \$100 ante—the mere price of Sunday brunch with your family, or one night's stay in a Denver hotel—but also your commitment, your problem-solving creative ideas, and your optimism. My cancer patients regularly ask me, "If I have a positive attitude, will I do better?" I always answer with a resounding "YES!" In truth, I do NOT know if it improves the OUTCOME, but it certainly improves the road traveled to get there!

What can we do to assure your support? "Trust me, I'm a Doctor?" HA!! "Follow ME and I'll show you The Way?" No, we can move forward only if we link arms and join spirits and form a TEAM in which we all have our own role. We need not all be alike. It is, in fact, our DIVERSITY that could give us strength. Can you imagine the New York Knicks winning the NBA if all 12 players were 7 foot, 270 pound centers? Or the New York Yankees winning even one game if all 9 players on the field were 100 mph strike-out PITCHERS?

No, I want a team with versatility and varied origins. I want us to have the depth to consider a hundred possible and impossible solutions before we choose the one with most promise. We must dare to think creatively. . .we must dare to take some risk. In our youth, who would have believed you could:

- sell watches without hands?
- buy music on Scotch tape
- walk on the moon?
- sell a sports shirt with no pocket and a little picture of an alligator?

No, we too must be willing to consider the novel approach—the "never-done-before-but why-not attitude. And here is my game plan.

Over 400 of you have already responded to my interest questionnaire since the Interim meeting in March. Recognizing that the standing councils, task forces, and committees number only about 150 and that you

have thus given me a surplus I can not use all at once, I will attempt to plan both diversity and credentialled expertise in my appointments. This will include bringing in "new blood to generate both fresh ideas and expand future leadership potential". I will encourage those leaders who currently wear several hats in multiple roles to pick a primary interest so they will not be over-worked while others of you are under-utilized. I pray that no one will perceive this intent to diversify and expand as discounting of their historical or continuing value to our cause; to reach out, we must risk giving up some of ourselves.

As you may recall from last September, when you recruited me as President-Elect, I have no personal ambition to be a hero; I strongly endorse the statement that progress is much easier if it does not matter who gets the credit. On the other hand I do **not** wish to be your Scapegoat. To *Kill the Messenger* is ancient history: Should I have areas of failure or disappointment to you, I would treasure your compassion rather than offensive street gestures.

It is my intent to function as your Facilitator, and in meetings I will likely function in that capacity: getting information from all; urging you to be concise, and state your intent up front; and, perhaps, interrupting if you get too loquacious or tangential to the topic at hand.

I will push for decision-making based on FACT rather than OPINION. I will ask CMS staff to assist us with data gathering so that we may learn from the successes and failures of others. I may consider the recruitment of outside experts to teach us what we do not know, and save us needless trial and error if possible. I will encourage us to LISTEN before we TELL—and that includes our critics as well as our consultants and colleagues. Externally, we will strive to regain our influence in the world around us by effective NEGOTIATION rather than FIAT.

And finally, once committed to a course of action, we will see it through to its conclusion, modifying if needed, but not vacillating in our

purpose. How many of you have heard of WALLKILL, New York? (reproduction of poster) This poster was made before the city fathers reneged on their commitment to a folk song concert 25 years ago that was ultimately held elsewhere down the road and became known as . . . (second poster) Woodstock! In 1995, we must avoid the paralysis of uncertainty, or someone else will hear the music!

What can YOU do to embrace 1995? In addition to supporting the Network Feasibility Resolution tomorrow and investing yourself in the committees and task forces of CMS and your component society, you can bring me your problems. I want so much to hear about your concerns that I have established TEL-DAVE, a direct line to me that you can call day or night to leave a message of one sentence or several verbal paragraphs. The number—which will be passed out with your reference committee reports tomorrow—is 303-930-0420. I will check for messages several times a day and return your call if you request.

There is, however, one stipulation: you must bring me a TWO-FISTED problem: in the one hand, the perceived difficulty; but in the other, a potential solution. I will have little time for whiners. I will give my all to help problem-solvers. So bring me your two-fisted issues: apparent problem and possible solution.

Secondly, you may wish to review **our** responsibility in bringing sanity back to Health Care. I show you my favorite *Far Side* cartoon: the clever bear in the crosshairs of a high-powered rifle has the presence of mind to urge the hunter to take out his companion.

Trumpet players use this pundit when they botch a high C at triple forte.

Applied to the House of Medicine, it is so tempting to blame the other player: the "selfish" specialist or the "stupid" gatekeeper, the trial lawyers, the insurance companies, the politicians. Of course, they **all** have a role in this huge mess. But we must bring order to our own house before we can negotiate with

outsiders.

I would like to suggest that we modify the message like this; that we burn this image into our brain; that every time this year we find ourselves pointing the finger elsewhere we will recall the targeted bear with a circle-slash and move back to **our** issue for which **we** are responsible. Let us learn to lead by **example** rather than by accusation. We may be surprised at the doors that will open!

And finally, you may wish to take a very careful look at yourself. For all the Dream-Come-True our lives may be, others may not see us as we see ourselves.

Several months ago I was attending a major medical convention in another city. A lady I know related being on the elevator in the hotel with two other women. One, lavish in expensive clothes and jewelry was loaded down with a half dozen shopping bags from Nieman-Marcus, Sachs Fifth Avenue, and Marshall Fields. Said one of the other

ladies, "Looks like you've had quite a morning!" "Oh," said the shopper, "I've saved so much money—everyone is having SALES!" "Seems to me you must have **spent** a lot of money", responded the first lady. "Oh, it doesn't matter," replied Ms. Nieman Marcus, "My husband is a **doctor!**"

Surely none of us would be so crass. But after hearing the story, I asked myself how often we looked sort of like that to others. Pretentiousness of spirit in our presentation to our associates, the nurses, our employees, the neighbors, retail clerks, insurance clerks, or the general public will win us no friends in an era when our virtue should glow and our shortcomings fade. We may feel **entitled** to our income, our position, our opinions, or our anger... but who respects **entitlement**? Let us from the core of our souls reflect the humble pride of the physician who really cares; the fortunate, highly skilled **servant** of those who need us!

So, "Here's Lookin' at You", Physicians of Colorado. What will we **see** in 1995? If we are going to Change Our Luck as we discussed at the Leadership Conference in May, we **must** begin inside ourselves as individuals:

What are our Strengths?  
What are our weaknesses?  
What are our goals?  
What are the realities?  
What are the delusions?  
And what can we DO?

We must put denial and anger behind us, and move forward to resolution.

We have a lot going for us. We are, in truth, very SPECIAL PEOPLE; We have had exceptional lives, and now we have exceptional responsibilities.

Are we up to it? I say "Yes! FOR SURE!"

So, "Here's Lookin' At You", my colleagues, my friends. May 1995 be the year of Renewing Our Dreams!

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# LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.  
Denver, Colorado  
(303) 861-1000

## Managing Employment Risks

Employment law is a diverse area that is controlled by judicial decisions, as well as legislative enactments. In an effort to manage the risks that they face, health care providers should be familiar with evolving topics in employment law.

- **Americans with Disabilities Act**—The Americans with Disabilities Act (ADA) prohibits employers with fifteen or more employees from discriminating against “qualified” individuals with disabilities. An employer is required to make reasonable accommodations for physical and mental limitations, when such limitations are known by the employer and accommodations would not impose an undue hardship on the business. An employer found in violation of the ADA may be required to pay compensatory, as well as punitive, damages.

- **Employment at Will**—While an employee hired in Colorado for an indefinite period of time works “at will”, allowing an employer to terminate the employee without cause, this doctrine is quickly eroding away as courts are recognizing more and more exceptions to the general rule. Health care providers must be careful when providing employee handbooks that outline an organization’s procedures and policies, and in making implied promises of long-term employment. Additionally, Colorado has passed a law protecting an employee from being discharged for engaging in lawful activities off of the work-site and during non working hours.

- **Liability for Payment of Wages**—Under most circumstances, the wages earned by an employee must be paid within ten days following the close of a pay period. Upon termination, employees are usually entitled to be paid almost immediately. Failing to comply with the wage laws may result in payment of penalties, besides payment of compensation due to the separated employee. Moreover, the wage laws have been interpreted to allow a separated employee to sue a company’s officers, personally, for unpaid wages.

- **Employees vs. Independent Contractor**—Classifying an individual as an employee or an independent contractor has an impact on the tax obligations of the employer. Both the IRS and Colorado provide guidelines for determining the existence of an employer/employee relationship or an employer/independent contractor relationship. Careful crafting of the relationship, on the basis of both IRS and state regulations, can help increase the odds of a determination in the employer’s favor.

Employment law is a growing area of concern for all employers. Health care providers should consult with attorneys familiar with employment law in order to increase their awareness of what both state and federal laws require in this expanding area. For further information, please contact:

A. Craig Fleishman, Managing Director  
Gelt, Fleishman & Sterling P.C.  
1600 Broadway, Suite 2600  
Denver, Colorado 80202  
(303) 861-1000

## EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney  
Executive Director  
Colorado Medical Society

**IT'S DONE!** Another Annual Meeting is over with. Another year of major changes in medical practice and health care delivery has come and gone.

But this one was different; there was an air of collegiality which has not been present in many a meeting. I can't put a finger on it, but I would have to say that it was due to the two outstanding President's Planning Sessions we have had this year and last. Yes, I think that's it. With the session held by Dr. Bill Bailey in Fort Collins a year ago, Colorado Medical Society commenced a metamorphosis which -- like the threatened bankruptcy back in 1984 -- brought the troops to the fore. There was a rush of adrenaline and everyone pitched in to help reorganize and update the Society to keep pace with the times.

Oh yes! It was tough; it was a lot harder on President Bailey than he wants to admit, because there were grueling, grinding times. There were personally crushing experiences and there were other experiences which made a person think "Hey, I didn't know I had that much power!"

I wouldn't mind telling you how tough it was on me; however, I won't.

Then comes 1994 and another outstanding meeting, this one at Vail when Dr. Martz said that along with reorganizing we have to "change our luck". He hasn't had an easy time of it either, but then, he's just getting his feet wet in the presidency, and the tougher times are yet to come. So much for togetherness.

Suffice it to say that togetherness meant a lot to the success of this "Annual".

Now, let me say something about the individual players -- the physician attendees. Not in all my experience at CMS have I seen an attitude like this year's. The meeting went so well because of the individuals, so give yourself a big hand. You made it all work in a truly democratic form and with excellent results. And I believe you would echo my feelings, because you certainly indicated on your evaluation sheets that this was one of the better meetings, from facilities to hotel staff to the meeting as a whole.

As is typical of this large an undertaking, we have to have staff people to bring it off successfully, and this year the CMS staff did an outstanding job, too. I want to commend them all for doing an excellent job under some difficult circumstances (mostly budget oriented). At the same time, I have to say something about the Hyatt Regency staff, which was cooperative and efficient throughout.

In all, I hope you found this meeting to be exceptionally productive for the good of the Society as a whole.

Dr. Martz and the rest of the leadership has set out a huge agenda for CMS during the coming year. We, the staff, will do our best to serve the Society in carrying out these charges.

Thanks for all your help in making the 124th Annual Meeting smooth, successful and a memorable experience.

*"...give yourself a big hand. You made it all work in a truly democratic form and with excellent results."*



## An open letter to CMS physicians

Dear Colleagues:

At the CMS Annual Meeting of September 8-11, 1994, your leadership (including not only the officers and the Board of Directors, but also the entire House of Delegates) voted overwhelmingly to pursue Phase II of the Colorado Physician Network Feasibility Study.

This decision was based on the following facts:

1. The survey of almost 400 CMS physicians conducted by Monaghan and Associates in the past few months has clearly established that the majority of you feel that managed care is here to stay, that physician leadership could impact the course of managed care, that there may still be time to attempt this, and that you are willing to invest a modest amount of money to explore this.
2. The experience in California and other states has supported the above conclusions. The California Medical Association has dramatically proven (and published in the news media) that physician-led organizations are far more favorable in economy **AND** quality to both patients and providers. They avoid the CEO salaries of multi-millions, and keep "administrative" expenses to a lean 6-7% instead of the 25-30% skimmed by proprietary enterprises.
3. The CMS Network Task Force has envisioned an aggressive approach to be enacted in the next 3 months which will include the hiring of an experienced consultant to clarify our options and strategy, as well as a market feasibility study to identify the potential scope of our project. **We do not intend to be an "also ran" in the managed care market!** We will pursue this project only if there is significant prospect of being a major player.

In order to fund Phase II of the Colorado Physician Network Feasibility Study, it is necessary to assess each active member the mere sum of \$100 — the cost of Sunday brunch with your family, or one night in a metropolitan hotel. In order to guarantee the success of this fund-raising, the House of Delegates voted to make this contribution **MANDATORY** and payable by November 15, 1994. (There is **NO** time for further delay!)

It has been recognized that our efforts **may** be "too little, too late", and there may be obstacles beyond our ability to overcome. Should that be the case, we will walk away and leave health care management up to the proprietary giants. You will lose only 100 bucks.

On the other hand, if we give up without trying, we will all lose far more, both for ourselves and for our patients. Your organization's leadership is therefore willing to invest hundreds of hours of investigation on your behalf in the next 3 months, recognizing the validity of "Nothing ventured, nothing gained".

The contribution is **NOT** optional, and we would appreciate it if you would respond immediately upon receipt of the assessment notice so we can get on with the project. If you have questions or concerns, please do not ignore this mandate and "drop out". We feel this is a small price to pay for a potentially great benefit, and would urge you to contact either your component society office, the CMS state office, or one of the officers, directors, or delegates to discuss your issues.

We have the opportunity to regain control of our destiny . . . but we need your \$100, your creative ideas, and your support to make it happen!

Sincerely,



David C. Martz, M.D.  
CMS President, 1994-95

P. S. For the **rare** physician who feels that his/her employment with an existing managed care organization would create a conflict of interest in this feasibility study, you may designate that your \$100 assessment be applied to other non-competitive projects by CMS.

## CMS Network Fact Sheet

The Colorado Medical Society believes that a physician directed managed care organization can produce superior quality and efficiency while maintaining the integrity of the traditional physician/patient relationship. The Medical Society has proposed development of such an organization which will strive to:

1. Improve the value of health care delivered.
2. Facilitate the ability of the patient to choose a high quality physician.
3. Compete on the basis of value and quality.
4. Optimize physician/patient roles in clinical decisions.
5. Enhance physician access to patient populations.

At the September 1993 annual meeting of the Colorado Medical Society (CMS) House of Delegates, approval was obtained to create a task force to study possible development of a statewide physician managed organization.

The Network Task Force was created and strongly recommended to the House of Delegates at its March 1994 meeting that a survey be conducted of the CMS membership to determine the level of interest that exists before moving ahead with development of a physician organization. Authorization was obtained at that meeting to conduct a membership survey.

Monaghan and Associates, a Denver consulting, research and strategy firm, was chosen as the firm to conduct the CMS membership survey. The Task Force worked closely with the consulting firm on issues such as survey content, questions and follow up activities. The survey consisted of a telephone questionnaire as well as a number of focus groups conducted around the state. A number of survey findings are listed below:

- A majority of physicians believe managed care is here to stay and that physicians need to have a stronger voice within the system.
- Physicians believe that if they can play a stronger role in managed care, the primacy of the physician/patient relationship can be maintained.
- Physicians recognize the importance of controlling the financial side of the equation. They are unsure about creating a stand-alone HMO, but do support a joint venture with a capable physician-friendly insurance provider.
- Several benefits of a statewide physician managed organization were cited:
  - Provides out of region coverage
  - Strong marketing position
  - Provides negotiating strength
  - Access to necessary and sophisticated data base
  - Access to a unified information system
- Three-quarters of physicians polled believe it is important for CMS to pursue development of a managed care organization.
- Physicians are sufficiently motivated to support some type of bold move in managed care.

Given the level of support for a CMS sponsored physician owned health care organization indicated in the survey, the Network Task Force recommended that CMS move to the next phase of development. Authorization was obtained at the September 1994 House of Delegates meeting to conduct a study to determine the feasibility of developing such an organization.

The feasibility study will include:

### Market Analysis

- Purchaser survey (employers, government programs, self-insured groups, labor etc.)
- Study the competition, their market share etc.
- Identify niche markets

### Product/Business Plan Development

- Product Design
- Recommend governance and organizational structure
- Identify start-up costs (actuarial, legal, marketing, information systems, etc.)
- Develop financing options
- Identify reimbursement mechanisms
- Identify utilization management mechanisms

### Member Education

- Inform membership as development progresses
- Educate members on the need, costs and benefits of the organization

An experienced consultant will be hired through a request for proposal process to conduct the feasibility study. If the study finds that development of a statewide physician organization is not feasible or is "too little, too late," or has obstacles beyond our ability to overcome, the project will be discontinued. If the study determines that creation of such an organization is feasible, development will continue.





# The 1994 Constituent Skills Workshop

October 28, 1994—CMS Board Room

*You've already invested a minimum of 4,380 days of your life to learning the healing arts. Can you afford not to invest a half day in the political arts in order to avoid having your practice run by lawyers and bureaucrats?*

## **Are you willing to let others decide the future of health care?**

Health Insurance reform is far more than just another political issue. It will determine how you will practice medicine in the future. And that's just number one on a long list of health-related political issues.

## **Who can best represent your interests?**

You, the individual physician, are often the most effective representative of the cause of medicine in the political arena. You have the specialized knowledge and ability to get your voice heard — if you are willing to act.

## **I voted — Isn't that enough?**

Grassroots activism really gets the attention of lawmakers. And who isn't willing to listen when his or her own personal physician calls with an opinion?

Many people are frustrated with the government. You are the one who can do something about it. This workshop will teach you to write an articulate letter that will make your representative sit up and take notice. You'll be on the list of people called for an opinion when health care issues come up.

## **AGENDA**

- |          |   |
|----------|---|
| 8:30 am  | Continental Breakfast   |
| 9:00 am  | Welcome<br><i>Richard Allen, MD</i><br>Introductions<br><i>Michelle Johnson, AMPAC</i>  |
| 9:15 am  | The Political Environment for Medicine — Why Grassroots Political Action is Necessary<br><i>Mike Dunn, President, Michael Dunn &amp; Associates</i> |
| 10:00 am | Understanding the Legislative Process   |
| 10:45 am | Break   |
| 11:00 am | Becoming a Player in the Legislative Process  |
| Noon     | Adjourn   |

## **Space is Limited! Register Early!**

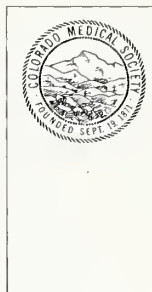
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City, State, Zip \_\_\_\_\_

Please fill out this form, place it in an envelope and mail it to:  
Government Relations—Colorado Medical Society  
PO Box 17550  
Denver CO 80217-0550

For more information call 303-779-5455 or 1-800-654-5653



## PROCEEDINGS OF THE HOUSE OF DELEGATES ANNUAL MEETING 1994

The Colorado Medical Society House of Delegates met at the Hyatt Regency Resort, Beaver Creek Colorado, September 9 - 11, 1994 and took the following actions:

### REFERENCE COMMITTEE ON BOARD OF DIRECTORS/ CONSTITUTION & BYLAWS

**Adopted** a Resolution to sponsor an Essay Contest on the subject of Health Care Reform.

**Adopted** a Resolution which requests the Presidents of the Component Societies to meet and consider ways and means of increasing membership.

**Adopted** a Resolution which called for the Colorado Medical Society to adopt the Rules of Order published by James E. Davis as its standard for all meetings.

**Adopted** a Resolution for a Membership Dues Increase for Active Members.

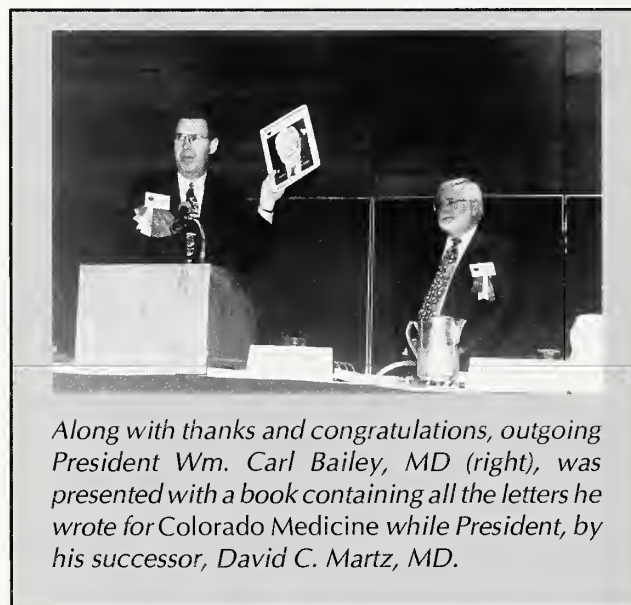
**Adopted** a Resolution which changed the drop date for non payment of dues.

**Adopted** a Resolution which encourages physicians to participate in Project USA.

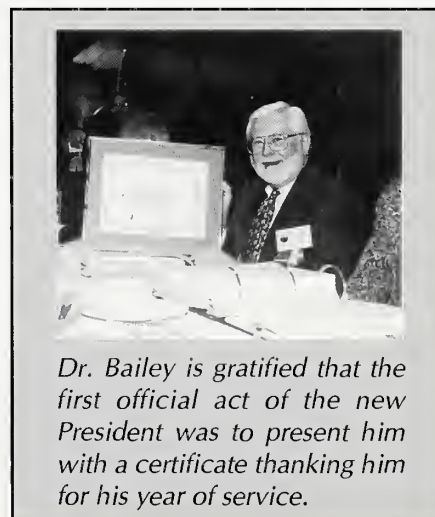
**Adopted** a Resolution which includes the current president of the Colorado Medical Society Alliance as a member of the Council on Legislation.

**Adopted** a Resolution which authorized the Colorado Medical Society to proceed with the next phase of development of a statewide physician owned and controlled organization and to fund this phase with a one time member special assessment of \$100.

**Adopted** a Resolution to abolish the rotation for the nomination of President-Elect.



*Along with thanks and congratulations, outgoing President Wm. Carl Bailey, MD (right), was presented with a book containing all the letters he wrote for Colorado Medicine while President, by his successor, David C. Martz, MD.*



*Dr. Bailey is gratified that the first official act of the new President was to present him with a certificate thanking him for his year of service.*





# ANNUAL MEETING 1994



*Dr. Bailey had the privilege of presenting several awards at AM 94. Among them were (bottom) the President's Certificate of Service to Jack L. Berry MD for his work on rural health issues, (middle) the A.H. Robins Award for Community Service by a physician to Dr. Richard Kemme, and (top) the pins to new members of the 50 year club who were in attendance. The 50 year club members shared a smile with the youngster who was retiring as President.*

## Accepted for filing:

- Progress Report - AMA Delegation
- Progress Report - Board of Directors
- Progress Report - Council on Ethical & Judicial Affairs
- Progress Report - Executive Director
- Progress Report - CMS Education & Research Foundation
- Progress Report - Network Task Force
- Progress Report - Organizational Study Committee
- Progress Report - Women in Medicine Section

## REFERENCE COMMITTEE ON HEALTH AFFAIRS

**Adopted** a Resolution which defines a revised policy for the Colorado Medical Society regarding Non Physician Providers.

**Adopted** a Resolution that sunset previous policies regarding Non Physician Providers.

**Adopted** a Resolution which defines policy for the Colorado Medical Society regarding the corporate practice of medicine.

**Adopted** a Resolution which changes the Bylaws to accommodate the combination of the Professional Education and Accreditation Committees.

**Adopted** a Resolution that defines Colorado Medical Society policy on School Based Health Centers.

**Adopted** a Resolution which enumerates the various ways and means which the Colorado Medical Society will use to assist rural physicians and rural medicine.

**Adopted** a Resolution to charge the Youth Task Force to pursue a project on comprehensive health education in the schools, including community program planning, educational consultation, advocacy and promotion and provision of education.

**Adopted** a Resolution which calls for CMS to pursue the development of a statewide standard credentialing form to be used by all physician credentialing entities.

**Adopted** a Resolution which directs CMS to implement a task force



to study integrated health systems and formulate strategies for the membership to successfully deal with integrated health systems.

**Adopted** a Resolution which sunsets the Continuing Medical Education (CME) Mission Statement in the Bylaws and adds the statement to the Policy Manual.

**Adopted** a Resolution which sunset current non physician provider policies.

**Adopted** a Resolution that the Colorado Medical Society reaffirms its position that CMS physician input and guidance be sought in the development of health care guidelines.

**Adopted** a Resolution that the Colorado Medical Society endorse the accreditation program for office laboratories of the Commission on Office Laboratory Accreditation (COLA) and encourages physicians to seek clinical laboratory accreditation through COLA in lieu of federal certification.

**Accepted** for filing:

Progress Report - Health Affairs Council  
Progress Report - Council on Legislation  
Progress Report - COMPAC

## REFERENCE COMMITTEE ON THIRD PARTY PAYOR ISSUES

**Adopted** a Resolution which was a compilation of current policy on managed care.

**Adopted** a Resolution which amended a portion of the current policy on managed care not included in the compilation rewrite.

**Adopted** a Resolution which sunset the existing managed care policy.

**Adopted** a Resolution which defined Colorado Medical Society position and policy on managed care and antitrust.



*Dr. Bailey also honored Senator Claire Traylor of Wheat Ridge (top) for her very effective efforts in the state legislature on behalf of health care and Lorraine Koehn, CMS Director of Government Relations (above) as the Staff Person of the Year. Below, K. Mason Howard M.D., Past President of the CMS and soon-to-retire CEO of the Copic Insurance Company, was honored for his service by the Medical Executives Group.*







## ANNUAL MEETING 1994



(top) Joel M. Karlin, MD confesses to being speechless for the first time in his life as he accepts the honor of being installed as CMS President-Elect for 1994-1995 after a closely contested race with Gary D. Vander Ark, MD.

(below) John F. Farrington, MD describes the proposal for a feasibility study on a state wide physician-run health care network, with additional information on similar efforts in California being provided by Marie Kuffner, MD (bottom). The Resolution authorizing the study was passed by the more than 220 representatives of Colorado physicians in the House of Delegates.



**Adopted** a Resolution which amended certain portions of the Health System Reform Policy.

**Adopted** a Resolution which directs the CMS American Medical Association Delegation to monitor the progress and evolution of the Patient Protection Act Legislation and to disseminate this information to CMS membership.

**Adopted** a Resolution that the Colorado Medical Society may employ a physician who will interface with health plans doing business in Colorado to implement affiliation/disaffiliation criteria and assist member physicians in dealing with these entities.

**Adopted** a Resolution that the Colorado Medical Society advocate the philosophy of citizen and physician involvement in the development of health care priorities.

**Adopted** a Resolution that establishes legislative priorities in the health care arena include point of service options and patient choice of health plans in health purchasing cooperatives.



Colorado's Democratic Governor Roy Romer and his Republican challenger Bruce Benson presented their ideas and fielded questions from the audience in a lively session at a luncheon sponsored by COMPAC and the CMS Alliance.



# ANNUAL MEETING 1994



*These are the people who represented you in making the decisions on the preceding pages. Please thank them for their participation.*

## AFFILIATION

Registrant

## AMERICAN MEDICAL DIR. ASSOC.

Solomon, William

## ARAPAHOE

Baack, Judy  
Bartee, Roy  
Barter, Jeffrey  
Bartlett, Max  
Boulder, Joel  
Brenneman, Janice  
Burks, Jack  
Capek, Richard  
Gulevich, Steven  
Jolly, Susan  
Larkin, Thomas  
Lazarus, Jeremy  
Levine, Mark  
Lewis, Frederick  
Ozog, Mark  
Price, Jerry  
Scanlon, Charlotte  
Stecher, Karl  
Stone, James  
VanderArk, Gary

## AURORA-ADAMS COUNTY

Gottula, Roderic  
Greos, Leon  
Heaton, Angeline  
Heaton, Carl  
Jalota, Renu  
Manguso, Robert  
Press, Peter  
Rich, John  
Sherman, Eugene  
Sundland, Barry  
Visconti, Paul  
Vitanza, Joanne

## BOULDER COUNTY

Benson, Alan  
Berg, Kevin  
Bolles, Gene  
Carr, Alfred  
Farrington, John  
Kelley, Severance

Mooney, Herbert  
Rupp, Gerald  
Steinbaugh, John  
VanHook, Charles  
Williams, William  
Wilson, Don

## CLEAR CREEK VALLEY

Brundige, Richard  
Campbell, Bernard  
Cedars, Chester  
Day, James  
Doig, William  
Eaton, Wyley  
Furman, Joseph  
Glismann, John  
Golbert, Thomas  
Henbest, Philip  
Laubach, Sherri  
Mains, Charles  
Mozia, Nelson  
Netz, Howard  
Oppenheim, Walter  
Parry, Lynn  
Sadler, Dean  
Tegtmeier, Ronald  
Yocum, Harold

## COLO. GYN. & OB. SOCIETY

Burke, Shannon

## COLO. SOCIETY OF

CLINICAL  
PATHOLOGISTS  
Stienmier, Richard

## CURECANTI

Hopple, Lynwood

## DENVER

Allen, Richard  
Bakemeier, Richard  
Barmatz, Hirsh  
Bogin, Robert  
Bumgarner, Frank  
Butterfield, Donald  
Byrns, Patricia  
Campbell, William  
Carson, Bonita

Claassen, David  
Cook, William  
Davis, Kevin  
Foust, Glenn  
Hedberg, John  
Hutchison, David  
Jacobs, Mary Jo  
Jacobson, Eugene  
Kandel, George  
Karel, James  
Kelble, David  
Kinzie, Jeannie  
Manart, Frank  
McCartney, Robert  
Nelson, Nancy  
Ratigan, Richard  
Reed, Barbara  
Rhodes, Edward  
Rumack, Carol  
Sawyer, Robert



*One of the highlights of this year's meeting was a melodrama featuring, among others, Ray Painter, MD of Glenwood Springs (left), CMS Executive Director Sandi Maloney (center), and Ted Lewis, MD of Colorado Springs (with "Boo" sign), shown here practicing their parts.*





## ANNUAL MEETING 1994

Schramm, Victor

Sides, Leroy

Stigler, Del

Walker, Louise

### **EASTERN COLORADO**

Olson, Mark

### **EL PASO COUNTY**

Barry, Francis

Brusenhan, Richard

Cole, Norman

Crawford, Lewis

Emeis, William

Feinsod, Fred

Genrich, John

Gieringer, Gary

Gifford, Marilyn

Hanson, Jerry

LaVoo, John

Lloyd, William

Moore, Larry

Nielsen, Peter

Pollard, Joseph

Rapp, Alan

Rubinow, Sidney

Simerville, James

Spaulding, Duane

Struck, Teresa

### **FREMONT COUNTY**

Vincent, Jack

### **HUERFANO COUNTY**

Unrein, Christopher

### **INTERMOUNTAIN**

Cohen, Edward

### **LARIMER COUNTY**

Abbey, David

Belleville, Bruce

Chase, Jerry

Ezell, William

Giansiracusa, Richard

Hammond, Richard

Honea, Bertrand

Kaiser, Dale

Nemeth, Clifford

Stephens, Floyd

Tagge, Gordon

Vedanthan, P.K.

### **LAS ANIMAS COUNTY**

McFarland, Douglas

### **MEDICAL STUDENT COMPONENT**

Fosburgh, Daniel

Johnson, Brian

Klancar, Lilly

Schossau, Tom

Wepman, Carolyn

### **MESA COUNTY**

Doran, John

Jones, Paul

Klein, M. G.

Linnemeyer, Robert

Magraw, Bronwen

Sadler, Theodore

### **MORGAN COUNTY**

Thompson, Patrick

### **MT. SOPRIS COUNTY**

Painter, Ray

Rodriguez, José

### **NORTHEAST COLORADO**

Rish, Ronald

### **OTERO COUNTY**

Berg, Mary

### **OTOLARYNGOLOGY & MAXILLOFACIAL SOC**

Shaw, Cameron

### **PUEBLO COUNTY**

Drake, Robert

Gaide, Thomas

Luebke, Donald

Markusfeld, Jack

Morgan, Alethia

Proctor, Carla

Reichert, Thomas

Ryals, Jarvis

Snyder, Charles

### **SAN LUIS VALLEY**

Brownrigg, Richard

### **WASHINGTON-YUMA COUNTY**

Berry, Jack

### **WELD COUNTY**

Bradley, Robert

Flower, Thomas

Kemme, Richard

### **WOMEN IN MEDICINE SECTION**

Bublitz, Deborah



### **DONALD J. NORTHEY, M.A.**

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## BOARD HIGHLIGHTS



### HIGHLIGHTS OF BOARD OF DIRECTORS MEETING - September 8, 1994

- Copic:** Dr. Howard reported that Copic has insured a hospital for the first time.
- CMSA:** Ms. Patti Brown, President, announced that Colorado ranked fourth in contributions to the AMA/ERF.
- AMA:** Ms. Nancy Kintzel, AMA Field Representative, was present and reported on the AMA activities in the Legislative arena. She also announced there would be advertisements on CNN featuring Dr. McAfee.
- Board of Directors:** The Board approved a motion to develop an educational page in *Colorado Medicine* on health care reform issues which could be used by physicians in their offices to educate and communicate with their patients.
- The Board approved revisions to the policy which provides for the appeal to an adverse accreditation decision.

### Annual Meeting presentation slides available

Copies of the slides used by Drs. Federgreen, McCafferty, Byrns, Alsever and Dean at the AM Educational Program are now available. To obtain any or all of them, call Sandy Finney at (303) 779-5455 or (800) 654-5653.

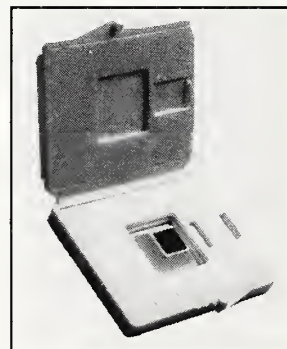
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# Rural Health is Important to All of Colorado

by Michael P. Thompson

*"Without the providers to deliver the health care, [universal access] is an empty promise, it just won't happen."*

Denise Denton,  
Colorado's office for Rural health

There are 63 counties in Colorado. Do you know how many of them are rural? If you define urban as having a community of 50,000 people or more, 52 of those 63 counties are rural. But, according to Denise Denton, Director of Colorado's Office for Rural Health, only 25% of the population lives in those wide open spaces.

The health needs of rural areas are unique, however. They have a higher percentage of the state's mobile population, which includes not only migrant farm workers, but tourists as well. In Hinsdale County, for instance, with a year-round population of about 500, they have to figure out a way to meet the health care needs of up to 10,000 during the tourist season. Rural areas also have larger numbers of elderly Medicare patients with increasing health needs. Distances to health facilities are longer. Their *per capita* teen pregnancy rate is astronomical compared to urban areas, yet because there are higher total numbers of pregnant teens in cities, that's where the money for helping them goes. Rural areas have a much harder time supporting technology, such as MRIs, ultrasound, CAT scans, etc. because the patients who would use these services are scattered so thinly compared to their urban counterparts.

In some places, the very infrastructure we depend on is lacking. Ms. Denton cited the case of CMS member Dr. John Fox in Limon, who couldn't get a phone line for a fax machine until he moved across town. There are still places where you can't get a single line phone

system. Makes it kind of hard to get on the information superhighway or, as some have suggested, use interactive video to diagnose and treat patients.

Why should those in urban areas be concerned about these problems? After all, they concern a small portion of our total population and these people wanted wide open spaces or they wouldn't have moved there, right? That must be at least part of the thinking behind most health care reform efforts, because by definition, they are designed to "get the most bang for the buck" says Ms. Denton, and that means serving the needs of the concentrated population centers first and foremost. It's more efficient. If you want 95% coverage, you go where the people are.

On the other hand, there are some very good reasons for everyone to be concerned about rural health care. For example, what if you are flying over one of the rural areas and your plane crashes? How far do you want rescuers to have to come from the nearest medical facility? What level of trauma care do you want available there? What if your car slides off the road, down the steep embankment into the river? Do you want a helicopter that can lift you out in a few minutes, or a bumpy ambulance ride that takes several hours and exacerbates your injuries? You know which you'd prefer, but who's going to pay for all that out in the hinterland?

Speaking of paying, how much do you pay in societal costs for the lack of pre-natal care in rural areas? When a pregnant woman has to travel 60 miles each way for her

***Why should those in urban areas be concerned about these problems? After all, they concern a small portion of our total population and these people wanted wide open spaces or they wouldn't have moved there, right?***

appointment and find somebody to watch the kids for most of the day, she doesn't come as often. And don't forget immunizations and TB tracking, also lower outside the urban corridor.

Then there are the products you rely on. That delicious Rocky Ford cantaloupe you had with lunch, for instance. How much of what you paid for it reflects the added cost of the health care for the fruit grower's family? You can think of many more examples.

Then again, says Ms. Denton, there's just plain humanity. It's the right thing to do. Why should rural people have any less health care than anybody else?

No particular reason, you say, except that the number one rural health problem is a shortage of providers. There just aren't enough physicians even for the sparse population. According to the federal government, there are 50 Health Provider Shortage Areas in Colorado, and 40 of them are rural. This problem will only increase with health system reform and the move to managed care. As managed care plans and health alliances try to attract more primary care physicians, more rural people will be motivated to move into the city. According to Ms. Denton, "Without the providers to deliver the health care, [universal access] is an empty promise, it just won't happen."

If health system reform is phased in incrementally, as seems likely if it happens at all, rural areas will suffer disproportionately. Ninety-five percent access for instance, will leave out low-income people and

small businesses, which are largely rural phenomena.

The number two problem is lack of access to emergency medical services and transportation to medical services. Another question is how different state health plans will affect border areas and patients crossing to another state because they like the plan better.

Ms. Denton served on Hillary Rodham Clinton's Health Reform Task Force and she both learned a lot and had a lot of insight into what needs to be done. "They're really working hard in Washington," she says, "but all they're really doing is talking about the way we *finance* or pay for health care. We have to find local solutions for rural health care problems."

She is very upbeat about the potential for those solutions. For instance, rural health care is a great training ground for learning team work and experiencing a variety of problems. It's outstanding for training people able to see beyond their area of specialization. That means it should be widely promoted by medical schools and residency programs.

Besides, rural health care providers have had to do so much for so long with so little, they have discovered many valuable principles and techniques for solving the problems of access, cost containment and efficiency. And competition and regulation will probably force managed care plans to better serve rural areas, so that experience will be doubly valuable.

*Ms. Denton heads Colorado's Office of Rural Health, a unique, independent, non-profit organization governed by a board made up of a majority of rural people. They provide information, coordination and technical assistance to those working on rural health care.*





## LETTERS

August 25, 1994

To: the editors and Dr. Frederick Lewis, Jr.

*(This is somewhat in response to the letters printed in response to recent legislation and somewhat a call for peace).*

I am sick and tired of hearing from specialists how generalists aren't as efficient in providing care, when specialists don't see what we do. It is true that there are certainly cases where a generalist has seen a patient several times for a problem which a specialist solves in one visit, belatedly. There are also probably 10 other cases where the generalist helped the patient without consulting a specialist, and at far less cost. There will also be the cases where the specialists have sent the patient bouncing from one to another, when a generalist, looking at all the problems, could have solved the mystery. I often see a patient for two or three problems and handle them all in one visit — at far less cost to the patient and the system than had they seen the three specialists it would otherwise have needed.

Having said all that in defense of generalists, it is time for the generalists and specialists to stop this war! We all need each other even though the balance of how many of each is going to change. As more and more of third party payors require a gatekeeper, the generalists may well be in charge. It's time for us to stop trying to battle each other and instead, educate each other on what we do best. Referrals work best when

the generalist and specialist are working together to best help the patient in a timely fashion rather than prove to each other who provides the better care.

There is something else the specialists might want to think about. Since generalists are likely to be the gatekeepers controlling many referrals, we are far more likely to refer to those specialists who support what we do. Those specialists who refuse to see the value in generalists may well find themselves out in the cold.

Sincerely,

Mary E. Fairbanks, M.D.

Dear Editor,

"It's the cancer again". These words struck terror in me as they were spoken in November of 1992. It seems my tumor markers had doubled and there was a small tumor that lit up my bone scan and mottled my MRI of the vertebral body of T12. I had tackled this deadly cancer once before, but that was over three years ago and I had hoped it was gone. My mind and body were numb with fear as the machines probed my body for more. The terminology of my training echoed in my core: Stage 4, metastatic, Hospice, Death and Dying.

I knew a little about bone marrow transplants, but none of it was good. My best friend in medical school had lost her husband after a transplant. It seemed that my darkness encompassed all of my colleagues, until I spoke with Dr. Robert

Rifkin. Rob graduated one year before I did in medical school and it seemed that he and I were always on the same rotation, with him being one notch above me. I knew he was smart, but here he was the head of the bone marrow transplant unit that I had just entered for evaluation. He was a bright light in the sea of blackness. He was calm and supportive, while explaining the difficult road we would be going down together. It must have struck very close to home, as he showed the research to me, his friend, his colleague, his fellow alum.

Thirty eight days of "isolation", Sleep deprivation, hair loss, mouth sores, TPN, 8 IV lines, esophagitis and utter fatigue were all a part of my ABMT experience, but so were the members of the CU alum, who were my healers in daily attendance. We all remember the support we got from our classmates in the Anatomy Lab, studying Biochem, during rounds on the Wards, but none was more gratifying than the love I received from my fellow alums during my most difficult of rotations in the bone marrow unit.

*Written by Billee W. Hardy, M.D. on the day of her first cancer-free anniversary of her Bone Marrow Transplant.*

## Sexual Misconduct Policy and Change of Jurisdiction - Adverse Information

The COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS considered requests from two component societies regarding Change of Jurisdiction and the sharing of adverse information. Following extensive discussion, the Council recommended the following.

Because CMS has no jurisdiction over local members, action must be taken at the component society level.

A physician who requests a change of jurisdiction from his current component society must obtain a waiver from that society before transferring to another society. If said physician is currently under investigation by his component society's Grievance Committee, the component society *must not grant such a waiver until the investigation has been completed.*

The Change of Jurisdiction Form should include a statement similar to the following: "No investigation against this physician is currently pending before this society."

## New Committee Appointments

David C. Martz, MD, CMS President, has announced the following 1994-95 committee and council appointments. They were ratified by the Board of Directors on

September 11, 1994. Additional appointments will be announced soon. Incumbents are designated by an asterisk.

### EXECUTIVE COMMITTEE (FOUR AT-LARGE MEMBERS)

Tom Allen, MD, Larimer County Medical Society  
John O. Cletcher, MD, Boulder County Medical Society  
Louise McDonald, MD, Denver Medical Society  
\*Bob Yakely, MD, Clear Creek Valley Medical Society

### FINANCE COMMITTEE (THREE AT-LARGE MEMBERS)

\*Muryl Laman, MD, Pueblo Medical Society  
George Shanks, MD, Mesa County Medical Society  
Susan Sherman, MD, Aurora/Adams Medical Society

### NETWORK TASK FORCE

\*John F. Farrington, MD, Boulder Medical Society, Chair

### ORGANIZATIONAL STUDY COMMITTEE

\*John A. Sbarbaro, MD, MPH, Denver Medical Society, Chair

### CMS EDUCATION AND RESEARCH FOUNDATION

\*W. Gerald Rainer, MD, Denver Medical Society, Chair

### WORKERS' COMPENSATION ADVISORY COMMITTEE

\*John Hughes, MD, Arapahoe County Medical Society, Chair  
\*Bruce Belleville, MD, Larimer County Medical Society  
\*J. Tashof Bernton, MD, Denver Medical Society  
\*Wyley Eaton, MD, Clear Creek Valley Medical Society  
\*L. Barton Goldman, MD, Arapahoe County Medical Society  
\*David C. Greenberg, MD,

*A monthly report of current and ongoing activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.*



# COMMITTEE • UPDATE • COUNCIL • SECTION

Here are the meetings of the **WORKERS' COMPENSATION ADVISORY COMMITTEE**, John Hughes, M.D., Chair, for 1995. The meetings will remain on the first Wednesday of the month, and be held bimonthly at 7:00 AM.

January 4, 1995

March 1, 1995

May 3, 1995

July 12, 1995

(Due to the July 4, 1995 Holiday)

September 13, 1995

(Due to the CMS Annual Meeting)

November 1, 1995

No meeting in December

If needed, emergency meetings will be scheduled.

Arapahoe County Medical Society

\*Fred Groves, MD, Weld County Medical Society

Fred Lewis, MD, Arapahoe County Medical Society

\*Brent Lovejoy, DO, Arapahoe County Medical Society

Robert Pero, MD, El Paso County Medical Society

\*Karl Stecher, MD, Arapahoe County Medical Society

\*Dennis Waite, MD, Denver Medical Society

\*Harold Yocum, MD, Clear Creek Valley Medical Society

## **HEALTH SYSTEM REFORM TASK FORCE**

\*Muryl Laman, MD, Pueblo County Medical Society, Chair

## **DATA COMMITTEE**

\*Tricia Byrns, MD, Denver Medical Society, Chair

## **TASK FORCE ON YOUTH**

\*Mark Johnson, MD, Clear Creek Valley Medical Society, Chair

\*Donald Cook, MD, Weld County Medical Society

\*James Delaney, MD, Aurora/Adams Medical Society

\*John W. Ogle, MD, Denver Medical Society

\*Richert Quinn, MD, Weld County Medical Society

\*James E. Shira, MD, Denver Medical Society

\*Karyl J. Ting, MD, Clear Creek Valley Medical Society

\*Reginald L. Washington, MD, Denver Medical Society

\*David W. Wells, MD, Aurora/Adams Medical Society

\*Larry Wolk, MD, Denver Medical Society

## **COMMITTEE ON PROFESSIONAL EDUCATION AND ACCREDITATION**

\*L. H. Stahlgren, MD, Denver Medical Society, Chair

## **COUNCIL ON LEGISLATION**

Richard Allen, MD, Denver Medical Society, Chair

\*CMS Alliance Slot

\*Guillermo Davila, MD, Denver Medical Society

\*Ben Galloway, MD, Denver Medical Society

Perry Haney, MD, Denver Medical Society

David Hutchison, MD, Denver Medical Society

\*Stuart Greisman, DO, Arapahoe Medical Society

\*Mary Jo Jacobs, MD, Denver Medical Society

\*Sherri Laubach, MD, Clear Creek Valley Medical Society

Joel Levine, MD, Denver Medical Society

\*M. Ray Painter, MD, Mt. Sopris Medical Society

Eugene Pflum, MD, Pueblo Medical Society

\*Darrell Thatcher, MD, El Paso County Medical Society

Chris Unrein, DO, Huerfano County Medical Society

## **MEDICAL PRACTICE ACT TASK FORCE**

\*Steven Thorson, MD, Chair, Larimer County Medical Society

\*Wm. Carl Bailey, MD, Denver Medical Society

\*Bruce Baker, MD, Denver Medical Society

\*Gene Bolles, MD, Boulder Medical Society

\*Bonita Carson, MD, Denver Medical Society

\*Phillip Henbest, DO, Clear Creek Valley Medical Society

Richard Allen, MD, Denver Medical Society

\*James W. Meeuwsen, MD, Pueblo Medical Society



Photograph by Jerry Abramowitz

# LET'S STOP BUILDING WALLS AROUND THESE KIDS.

These children are just like other kids except for one thing. They have epilepsy. You know that, while some need special help, they don't need walls.

Walls of misunderstanding, overprotection, or prejudice still keep kids like these in classrooms away from other children and exclude them from sports, trips and other normal school activities.

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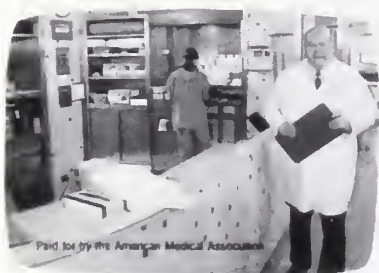


# American Medical Association

Physicians dedicated to the health of America



"Dr. Bob" :60



DR. McAFEE: Hello. I'm Bob McAfee. I'm a surgeon and I'm president of the American Medical Association. Right now, Congress is considering health system reform... that will affect...



every American for generations to come. And it will affect your relationship with your doctor. (MUSIC UNDER THROUGHOUT) DR. McAFEE: Everyday physicians hear what's important to their patients.



We know you want reform that will let you choose your own doctor and choose your own health plan.



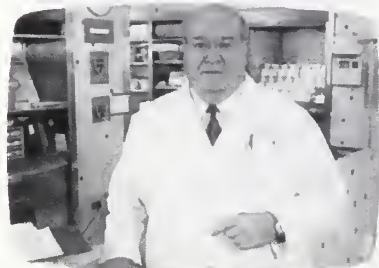
Reform that will let you and your doctor...



make medical decisions without interference from insurance companies.



Reform that protects the quality of care available to everyone.



We know what you want because you've told us.



So we're going to keep working with Congress to make sure health system reform is passed.



that protects your rights as a patient and your relationship with your doctor.



It won't be easy.



But you have our pledge that we're going to do everything we can to make it happen.



(MUSIC)

# AMA Launches First Ever Television Ad Campaign

The American Medical Association is stepping up its health system reform advertising campaign by entering the arena of paid television advertisements for the first time. AMA President Robert E. McAfee, MD, stars in the "Dr. Bob" spot which will air on CNN, CNBC and several Washington, DC area stations.

In the ad, Dr. McAfee speaks directly to patients, telling them physicians are "working with Congress to make sure health system reform" is passed that protects patient rights, quality care and the patient-physician relationship. It promises the AMA will work for reform "that will let you and your doctor make medical decisions without interference from insurance companies."

Dr. McAfee, a surgeon from Portland, Maine, says, "As we have said for over four years, the status quo in our health system will not do. And unfortunately, the will to correct the problems with our health delivery system may be slipping. Our ads say clearly that we will continue to push for health reform until we get what patients need and deserve."

The commercial advocates reform that would protect the right of patients to choose their physician (an AMA priority, as noted in their "My Doctor, My Choice" campaign, mentioned in *Colorado Medicine* for July, 1994, pp. 233-4), their health plan and to ensure that medical decisions are made by physicians. Dr. McAfee maintains that physicians are facing increased interference from insurance companies in making patient care decisions.

Dr. McAfee also outlined the



*Robert E. McAfee, MD, AMA President, shooting the "Dr. Bob" Health System Reform spot.*

AMA's Patient Protection Act, which calls for increased tobacco taxes, insurance reforms and professional liability reforms as items possible to achieve in the next month.

This half million dollar TV and radio campaign follows a four-year, multi-million dollar print advertising campaign by the AMA which includes such publications as *Time*, *Newsweek*, *US News and World Report*, *The Wall Street Journal*, *The Washington Post*, *USA Today*, and *The New York Times*. Says Dr. McAfee, "We will keep patients informed on what physicians think of these reforms and what action can be taken during the next weeks. Our hope remains that we can all see the beginning of reform before Congress adjourns."



# A Unique Fringe Benefit For CMS Members



## *Buying or Leasing a New Car???*

The **Colorado Medical Society** now provides a professional fleet management service to assist members throughout the state when purchasing or leasing a new vehicle. This service provides valuable vehicle information such as factory invoice costs, available options, technical data, consumer reports, etc.

Once your selection is firm, your purchase or lease will be arranged at **prices normally available only to large corporate fleets.**

Colorado Medical Society has endorsed Rocky Mountain Fleet Associates as a CMS member service, based on the satisfaction of the many physicians who have used their services over the past several years. These physicians have reported excellent results, **usually with savings of more than \$1000 from even the best negotiated showroom price.**

For more details, call **(800) 864-4388**. In Denver, **753-0440**.

***Colorado Medical Society***



## Influenza season is upon us again

Elderly people are twice as likely as younger persons to get pneumonia in connection with influenza, but only about 20% of those over age 65 get vaccinated. Those statistics are part of a publicity campaign designed to increase the incidence of vaccination among the elderly.

The Public Health Service lists all persons over age 65 as among those needing flue shots, regardless of their health status. Medicare Part B will pay for the shot with no deductible or coinsurance, up to their ceiling price. In addition, Medicare Part B will pay for pneumonia and hepatitis B vaccinations when the beneficiary is in the hospital, even though the hospital stay is covered under Part A.

Physicians are urged to recommend influenza vaccination for their elderly patients, as well as those with chronic or severe lung disease and those who are likely to be exposed to influenza in the workplace or elsewhere. This latter category includes physicians themselves, as well as their health care staff members.

## Vaccine Information Materials: VIMs Will Replace VIPs

by Judy Conner

Reprinted with permission from the Colorado Department of Public Health and Environment's quarterly

publication, the Immunization *Communique*.

New Vaccine Information Materials (VIMs) for MMR, polio, DTP and Td have been developed by the Centers for Disease Control and Prevention because of an amendment to the National Childhood Vaccine Injury Act (NCVIA). The amendment—signed into law on December 14, 1994—was designed to simplify the vaccine information materials and the process by which they are developed and revised.

The new VIMs are to be given by health care providers to the legal representative of any child **or any other individual** receiving covered vaccines (i.e., measles, mumps, rubella, polio, diphtheria, tetanus, pertussis).

Beginning October 1, 1994, **all** public and private providers who administer the vaccines noted above will be required to use the CDC-developed materials. The NCVIA amendment deleted language that allowed providers who buy their own vaccine the flexibility to develop their own materials.

Each of the new VIMs is one page printed on front and back. There are no signature blocks on the new VIMs since federal law no longer requires a signature. However, the Immunization Program has asked for an opinion from the State Attorney General's office regarding signature requirements under Colorado law.

The NCVIA still requires health care providers to make a notation in each patient's permanent medical record at the time the VIMs are

provided regarding: 1) date printed on the appropriate VIM (or on the Important Information Statement (IIS) for Hib and hepatitis B); 2) date the VIM/IIS was given to the vaccine recipient or the parent or legal representative; 3) date the vaccine was administered; 4) the manufacturer and lot number of the vaccine; and 5) the name and address of the health care provider administering the vaccine.

When they are received from the printer, the Immunization Program will be sending copies of the new VIMs and instructions for their use to all providers who use Program-supplied vaccine. We will send quantities of the new forms with vaccine shipments. Prior to October 1, 1994 you may use either the older VIPs or the VIMs.

**Note:** The Colorado Medical Society will send copies of the new VIMs, once they become available, to all providers who have received immunization forms from us in the past.

## Vaccines For Children Program Postpones Distribution to Private Providers

The August, 1994 edition of *Colorado Medicine* contained an informational article on the new federally-funded, state operated program, Vaccines For Children (VFC). The article informed readers that on October 1, 1994, the VFC program would begin providing





federally-purchased vaccine at no cost to all public health and private providers who agree to participate. However, in late August, the United States Congress canceled arrangements for VFC vaccines to be stored at, and distributed from a national warehouse. As a result of this decision the distribution of VFC vaccines to private providers will be postponed until an alternative distribution mechanism can be found. It is hoped that the private provider component of the VFC program will begin by January 1, 1995. Once the private provider component of the VFC program is up and running, notice will be placed in *Colorado Medicine*.

Questions regarding the VFC program may be directed to Jackie Murray at the Colorado Department of Health and Environment at (303)692-2798.

### **Violence Prevention Resource Manual Available**

The Violence Prevention Advisory Committee (VPAC), a 65-member, multi-disciplinary, multi-cultural, statewide advisory group, in conjunction with the Injury and Disability Prevention Program at the Colorado Department of Public Health and Environment, and the Center for the Study and Prevention of Violence in Boulder has developed a violence prevention resource guide for the state of Colorado.

"Violence in Colorado: Trends and Resources" contains over 300 pages of information on violence-related issues. The manual includes an overview of violence and associ-

ated risk/resiliency factors; articles and fact sheets on specific types of violence (child abuse, domestic violence, homicide, suicide, rape, gang violence, and more); "tip" sheets on what individuals can do to reduce violence and protect themselves from violent situations; and strategies for community organizations. County-specific background rates, and alcohol/substance abuse arrests and treatment) and trends in reported violence (rates for homicide, assault, sexual assault, child abuse, and suicide from 1988 to 1993) are also included. Reference material includes county-specific resource and referral information.

The cost of the Manual is \$10.00 per copy (which includes printing, handling & postage.) To order a copy(ies) send a request for the document, "Violence in Colorado: Trends and Resources" along with a check, payable to the Colorado Department of Public Health and Environment to:

Shirley Brewer  
Colorado Department of Public  
Health & Environment  
PPD-IP-A5  
4300 Cherry Creek Drive South  
Denver, CO 80222-1530  
or, call (303)692-2586.

### **Columbia to open another Colorado facility**

Changes in the health care industry may be leading to hospital closings and mergers, but that doesn't mean there isn't business for hospital corporations. The nation's largest hospital chain, Columbia Healthcare Corporation, has begun work on a second medical facility in Colorado,

in addition to the Plum Creek Medical Facility in Castle Rock. As part of its purchase of Medical Care America, which is expected to be finalized by the time you read this, Columbia is building the Midtown Surgical Center at 1919 18th Avenue in Denver.

The Center is to be an outpatient surgery center with "lower facility and administrative costs than inpatient facilities and ...better patient outcomes for outpatient procedures," according to Michael Curtis, vice president of The Neenan Company, selected by Columbia to design and build the facility. The Neenan Company, based in Fort Collins, also built the Plum Creek Facility and the Rocky Mountain Cancer Center, just two blocks from the Midtown Surgical Center, among others. Columbia plans to invest \$300 million in new medical facilities in the next several years, to augment their current holdings of over a billion dollars in medical facilities nationwide.

### **Doctors Without Borders needs MD's in Rwanda**

Doctors without Borders, U.S. Division, is seeking dozens of physicians to provide relief medical care to the nearly one million refugees pouring into Zaire.

In an interview with *Rhode Island Medical News*, Doctors Without Borders Administrator Leah Arnold, said that about 40 more medical personnel are being sought to leave for Rwanda within the next few weeks. Already there are 190 physicians and other health care personnel there who are in the process of assessing logistical needs.



Fully trained physicians who are fluent in French are especially needed to serve the two to three month tour. (Tours for Doctors Without Borders usually average about six months. Those with relief work experience are especially needed, Ms. Arnold said.

For more information about volunteering, please call Ms. Arnold at Doctors Without Borders at (212) 649-5961.

## CFMC to present educational program at its Annual Meeting

The Colorado Foundation for Medical Care (CFMC) will present its educational program, "A New Paradigm for Quality: The PRO-Provider Partnership," at its annual meeting on Wednesday, October 19, 1994, at Embassy Suites, 7525 E. Hampden in Denver.

CFMC has designed this program to help physicians and non-physicians develop their quality-improvement skills.

Topics will include:

- HCFA's direction
- The 5 W's of Quality Improvement
- Health Care Quality Improvement Program
- Medicare Quality, Indicator System

The program presentation will be followed by a reception and the annual meeting.

For registration information, call Kam Valentine or Kay Hawley at (303) 695-3300.

## Important CMS Dues Partial Non-Deductibility Notice

### Avoid trouble with the IRS

The Revenue Reconciliation Act of 1993 states that association dues used for lobbying activities are not deductible as a business expense. As a result, 10% of CMS dues and 33% of AMA dues for 1995 cannot be deducted as a business expense for federal income tax purposes. In addition, no portion of any dues paid to COMPAC/AMPAC can be deducted as a business expense on your federal income tax return. Neither medical society dues nor PAC contributions may be deducted as a charitable contribution.

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## RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

### **No politician will give this speech**

by **Jeff Greenfield**

The following is the text of a speech that neither President Clinton nor any other political figure will give during this election season.

**M**y Fellow Americans: As this campaign progresses, you will hear angry words aimed at all sorts of malefactors: criminals, illegal immigrants, lazy bureaucrats, welfare cheats, do-nothing congressmen, and arrogant members of the cultural and media elite.

Today, I want to single out a new target: you, the American people. Frankly, I'm sick and tired of hearing every blowhard politician proclaim that "the American people know what needs to be done.

Stuff and nonsense.

Most of "the American people" can't name their own member of the House of Representatives; they can't tell you within half a century when the Civil War was fought; and they couldn't find Rwanda on a map with both hands.

So don't tell me that "the American people" know "managed care" from "employer mandates" from "health alliances."

What the people do know is that they want somebody else to pay for all of their health care, and they don't want to pay for anyone else's.

Which reminds me: Let's talk for a minute about how "the hard-working, overtaxed American people don't want any more government in their lives."

First, compared to any other industrialized nation, we are the most under-taxed of all. Maybe that's as it should be, considering that we've always been more hostile to government than other countries; it's part of who we are.

But please — let us not insult each other's intelligence by pretending that you are "against government." That's ridiculously simplistic. Yes, there are some communities where you put out your own fires, bring your own garbage to the dump and police your own streets.

But most of us don't live like that.

And more significant, that "giant sucking sound" Ross Perot once talked about is the sound of millions of Americans looking for a place at the public trough.

You want government contracts for weapons we don't need anymore. You want your senator and representative to lug public money back to your neighborhood for a road, a pool, a gym, anything.

You want government to pay for your kid's college, for your grandma's arthroscopic surgery, for the national park you can camp at — but you don't want to admit it, because then you couldn't act so outraged when "the

government" tries to spend money on people who are different than you are. In fact, most of you are so deluded, you literally don't know what you believe any more. A recent NBC poll showed that two-thirds of you want the government to "cut entitlements" — but two-thirds of you are against cutting Social Security, Medicare and Medicaid.

What do you think "entitlements" are, anyway?

And do you know why you think this way about entitlements?

Because those of us in government, or who are running for office, have not had the guts to tell you that you're part of the problem.

Harry Truman was the last political figure who'd do it: In 1960, he said that any farmer who'd vote Republican after all the Democrats had done could go to hell. But Truman's not around anymore, so he can't help. I was going to talk about how overweight the average American is right now, or how the infidelity rate is over 50 percent for men and women, but I'm out of time. Maybe you get the message: Win or lose, I've had it with all this butt-kissing.

Here's my new slogan:

"No More Mr. Nice Guy."

*Jeff Greenfield, based in New York, is a political commentator for Universal Press Syndicate.*



# COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

October, 1994

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Volume 91, Number 11

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## A Vision for the Future



See Page 387...

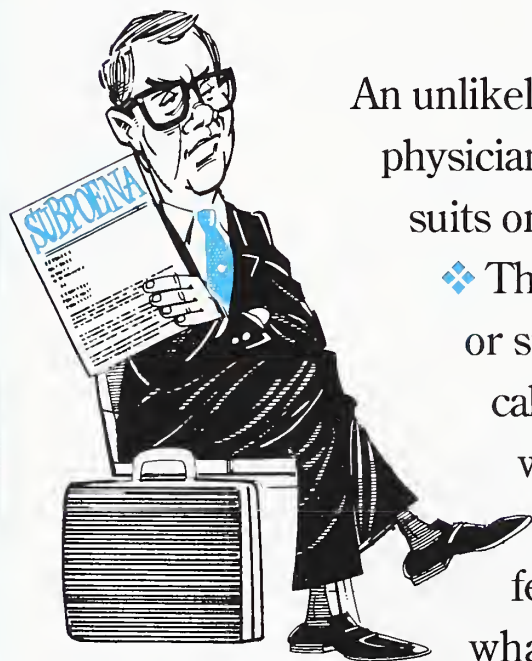
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# ‘Doctor, Doctor! Come Quick! There’s a Process Server in the Waiting Room!’



An unlikely scenario? Unfortunately, no. Colorado physicians are on the receiving end of malpractice suits on the average of once every seven years.

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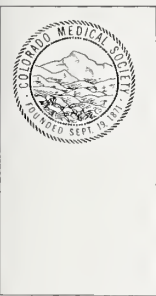
November, 1994

Volume 91, Number 11



## Cover Story

CMS President **David C. Martz, MD** would like to see an end to the friction between specialists and primary care physicians. See page 387.



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## A Vision for CMS

By the time you read this, two months will have passed since the Annual Meeting at Beaver Creek. So much has happened already, and yet we are just beginning to embark on our program for the year. Let's talk about our major objectives.

First and foremost, there is no doubt that this must be our Year of Unification. A House divided cannot stand, especially against the external forces which currently threaten us. It will be my Number one objective to attempt to bring peace and cooperation among the many elements of our medical community this year.

At the very top of my Must-Do list is the urgency to redress the unrest between "PCP's" and specialists. A "specialized generalist" myself as internist for 25 years practicing predominantly hematology-oncology for about 10 years, of rural origin and metropolitan training, I personally identify with BOTH worlds. As a physician committed to the primary responsibility of SERVICE to all humankind, and a sense of privilege to have that responsibility, I admire those who take pride and satisfaction in playing their own role in the medical arena while acknowledging and admiring the supplemental skills and interests of those physicians who do other things well. Always ardent humanitarians, we have fought against ethnic and gender discrimination for years—yet within our profession still lives the equally unjust "specialty" discrimination which erodes our effectiveness and belies our oath of collegiality.

As medical students we shared a

commonality that is lost as we diverge into specialty training, then specialty practice, then specialty lifestyles and mind-sets. Would that we could regain that global perspective of our more innocent beginnings.

Perhaps a day or two of "walking in another's moccasins" would help us individually to revise our perspectives. After all, we have done mini-internships for community leaders, mentorships for medical students: Why not treat ourselves to a Share My Day Program?

No time, you say? Perhaps ...but somehow we find a way to get away for a week or two on vacation now and again, a day or two for a meeting every so often, an afternoon or two for golf or fishing or mountain biking some times: What's so different about this option?

Perceived value? It might surprise you. Availability? It only takes a moment to ask a friendly colleague. Cost? Just your TIME: no registration/tuition fee, minimal travel. What an easy way to enrich your knowledge, broaden your perspective, and intensify a friendship in a few short hours. Think it over ...you may want to try it. (I will be spending a day soon with a rural PCP who has promised to show me a life I can hardly imagine — but eagerly anticipate.)

On a more organizational level, Dr. Richard Allen (Ob-Gyn and Legislative Council Chairman) and I have had lunch some time ago with Dr. Nicholas and Dudley — our counterparts in the Colorado Academy of Family Practice — to initiate potential integration of shared

*"First and foremost, there is no doubt that this must be our Year of Unification."*



problem-solving. In turn, we have been invited to attend the CAFP meeting in Vail on November 5th. In a broader plan of expanding our involvements, the first meeting of "COPS" (Coalition of Physicians) will be held at CMS on November 3rd, with empowered representative of all primary and specialty care societies invited to compare and contrast overlapping topics of mutual concern.

Furthermore, it is my intent to appoint a PCP-Specialist Task Force to work out guidelines we ALL can live with — even if we have to lock them in until they can reach consensus! And I dream of brainstorming a reimbursement program for managed care organizations which would NOT pit generalist and specialist against each other, either economically or authoritatively.

A second area of major commitment every year — and especially THIS year — is proactive legislative activity. The COMPAC Board, chaired by Dr. Robert Sawyer, has been hard at work interviewing candidates and designating specific ones to support. Many of us have been personally involved in the campaigns and financial assistance of numerous politicians.

Dr. Richard Allen has accepted chairmanship of this year's Council on Legislation. New to Colorado in the past year, he brings vast experience from his prior work with the medical association, the legislature, and the governor of Oregon, as well as a gentle confident style that facilitates camaraderie.

He, along with Dr. Karlin and myself and the CMS Government Relations staff, has initiated a legislative agenda that will be discussed at the first Council on Legislation meeting October 19th. We are already meeting with specific legislators in preparation for drafting the "Point of Service" and Rural Health concepts endorsed by the House of Delegates last month. It is likely that some components of Health Care Reform will be introduced in Colorado this year, and we are planning to participate in the formulation of these bills at the

earliest stages if possible.

The Medical Practice Act Task Force, led by Dr. Steve Thorson, has done a truly incredible job for Colorado physicians: their proposals have been almost universally accepted at this point in the preliminary hearings. And we will be paying special attention to the Non-Physician Provider issues in the Nurse Practice Act as discussed at the House of Delegates. This will be a VERY exciting year legislatively!

Obviously, the Network Feasibility Study is a top priority at this time. As of this writing, assessment returns are in the earliest phases; by the time you read this, we will have a clear idea of your response. This far, it has seemed beneficial to visit with you at your county meetings to explain the rationale of a Feasibility STUDY, and we have been on the road a lot the past two weeks to provide that background for you. By all reports, your Board members and Delegates have been giving excellent explanations during informal conversations. Meanwhile, we have offered about 25 consulting firms the opportunity to bid for the contract, and we will be reviewing their responses in the next two to three weeks.

Soon we will be pushing ahead with intensive exploration of Rural Health issues. Last year Dr. Jack Betty was a One-Man Task Force as he met with interested rural physicians in the four corners of the state. By early November, a full Task Force

with depth and breadth from medical student to resident to academic Family Practice educators to multiple practicing rural physicians will proceed under Dr. Berry's chairmanship to explore problems and solutions in depth.

Finally, we will take a closer look at membership expansion in the months ahead. Meeting the needs and interests of academicians and managed care physicians, as well as non-associated community practitioners, will necessitate special attention. Likewise, an expanded Credentialing Task Force, a study of Integrated Delivery Systems, and interactions with the Managed Care organizations are among the numerous other projects that will demand our attention.

It's going to be an exciting year! Your support and input will be essential. I will be contacting many of you as potential committee/Task Force members. I hope LOTS of you will take advantage of TEL-DAVE, my personal voice mail at CMS, to let me know what you are thinking. Simply call (303) 930-0420 and speak your mind. Remember, as I stated at Beaver Creek in announcing this Hot Line, I want only TWO-FISTED problems: your concern in the one hand, and a potential solution in the other. This is not a year for complaints without suggestions — it is a year for ACTION: join in, and we'll trade dreams for realities!



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## EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney  
Executive Director  
Colorado Medical Society

Dear Friends,

It was nine years ago that I left Blue Cross and Blue Shield of Colorado (BCBSC). As most of you know, I was the manager of Medicare Medical Policy and Support at BCBSC. I had been an employee of BCBSC for 15 years. During my employment, I spent all my time, except for special project work, in Medicare.

As we reported to you a couple of months ago, the Health Care Financing Administration (HCFA) announced that BCBSC had decided to not continue serving as the Colorado Medicare Carrier. HCFA also announced that, effective December 1, 1994, Blue Cross and Blue Shield of North Dakota would be the Medicare Carrier for Colorado. Because of my long tenure at BCBSC, I was saddened and troubled by the news. Saddened because some of my friends would likely be unemployed. Why troubled? Read on.

Let me tell you that I had visions of 1986. Most of you will remember what happened when BCBSC lost the Colorado Medicaid contract. The fiscal agent contract was awarded to a contractor from California. Among many other problems, your claims were not paid for several months and as a result, CMS sued the Colorado Department of Social Services. After several months of litigation, CMS finally negotiated a favorable settlement. This settlement is still in effect today. The contract was again in the hands of BCBSC and they have effectively handled the Medicaid contract for the past several years.

I don't believe that we will

experience the problems we did in 1986. Your staff has met with HCFA and BCBSC representatives. They have provided us with weekly updates on the status of the conversion. Today, Edie Register and I met with representatives from both BCBSC and the North Dakota Blue Cross and Blue Shield Plan. Here is the latest information.

- The new office location for North Dakota BCBS, operating as the Colorado Medicare Carrier, will be at 600 Grant, 6th floor, Denver.

- There will be no computer system conversion. North Dakota BCBS uses the same system as BCBSC.

- North Dakota BCBS has hired 49 people currently employed in Medicare by BCBSC. This is an advantage for us as we have developed a good relationship with employees of BCBSC.

- Conversion plans have been established to keep the pending claim count down below normal. This will minimize the problems which would be created if a large number of claims is on hand when cut-over occurs.

- There will be a full-time Medicare Medical Director on staff in Colorado. We applied pressure to HCFA regarding the importance of maintaining a local full time medical director. Our thanks to HCFA and North Dakota BCBS for making this happen. Grant Steffen, MD, has agreed to be stay on in this position.

- The Carrier Advisory Committee will remain in Colorado. (Those physicians who participate in the activities of this committee were not looking forward to commuting to

*"I am hopeful that it won't be 'Déjà vu - all over again'!"*



Fargo, especially in the dead of winter for these meetings. Having lived in the Dakotas while growing up, I don't blame them!)

- We were assured that there will be no immediate or drastic changes in medical policy. With the implementation of Physician Payment Reform, most medical policies have been "standardized".

- The new carrier will utilize the same provider numbers, at least for now.

- Claims needing to be crossed-over to Medicaid and private business will not be handled any differently. You should see no change.

- North Dakota will use Optical Character Reader (OCR) to scan newly submitted claims. Be certain to watch the Medicare Bulletins for complete instructions which may vary from the Colorado OCR system.

- North Dakota seems to be very interested in increasing the number of Colorado claims submitted electronically. In North Dakota, they have 90% of the claims submitted in this way.

- Most functions, except for the initial data entry of claims, will be performed at the Colorado headquarters. Some of the functions staying here are 1) on-site medical director, 2) suspended claims, 3) appeals, 4) fair hearings, 5) requests using the Freedom of Information Act, 6) provider inquiries, education, and assignment of provider numbers, 7) beneficiary inquiries, and 8) fraud and abuse.

- One question that remains unanswered is the mailing of the "Dear Doctor" letter and the disclosure reports. We understand that, until HCFA can clarify some issues, this matter is on hold.

I believe that both Blue Cross and Blue Shield of Colorado and North Dakota have taken steps to make the conversion as painless as possible. We will work closely with the new Carrier to develop a good working relationship - equal to the one we have with the current Carrier.

There is one person who will no longer be involved in Colorado

Medicare. I think we owe her a great deal of thanks for all the years she has worked with the physicians of Colorado. No, she didn't have all the answers but, she knew where to get them - and fast. I want to express my personal gratitude for all her efforts. She always gave personal attention to problems raised by the Colorado Medical Society. This person is Susan Schutte. A lot of you will recognize her name and after she's gone, we'll all clearly recognize how important she was to us.

In closing, I want to assure you that CMS staff will closely monitor the Medicare conversion. Please let us know if you have questions. As always, it is most important that you let Edie Register or me know of any problems you are having.

I am hopeful that it won't be "Déjà vu - all over again"!

# LEGAL UPDATE

*from Gelt, Fleishman & Sterling P.C.  
Denver, Colorado  
(303) 861-1000*

## Managing Health Care Risks

The field of risk management has grown significantly over the past decade. Health care providers are developing risk management programs to improve the quality of patient care, minimize the occurrence of adverse events, and reduce the risk of financial exposure. The degree of sophistication and appropriateness of a risk management program can help control the number of adverse incidents within an organization and reduce the risk potential of malpractice claims. Additionally, studies are finding that these programs have a direct correlation to reductions in dollars awarded for claims, and can be substantial factor in controlling insurance premiums.

A major factor in setting up any risk management program is the development of policies and procedures for identifying, evaluating, and prevention the occurrence of adverse incidents. Data is accumulated for analysis and evaluation through such sources as incident reports, patient satisfaction surveys, and case reviews. This data is useful in determining areas of high risk, identifying bad outcomes, and evaluating standards of patient care.

While data collection and analysis is important, the relevance of communication and patient satisfaction cannot be overemphasized. Simple policies such as modifying appoint-

ment schedules so that patients, and developing procedures for providing feedback to physicians and handling patient complaints can be crucial to developing a relationship that is less susceptible to conflict. Lack of communication and availability aggravates situations where malpractice claims may arise.

Managing risk in health care involves both proactive and reactive processes. Development of standards of care, patient evaluation programs, and patient/family counseling programs are examples of proactive strategies. Efforts to reduce the negative consequences of adverse events and responding to patient complaints are reactive, or responsive. Both processes should be incorporated into a risk management program to better influence the quality of patient care and minimize financial loss.

Risk management is a continuous process. Health care providers should work with their attorneys in developing, implementing, and maintaining risk management programs that improve the quality of patient care and reduce occurrences and consequences of adverse events. For further information, please contact:

A. Craig Fleishman, Managing Director  
Gelt, Fleishman & Sterling P.C.  
1600 Broadway, Suite 2600  
Denver, Colorado 80202  
(303) 861-1000



# You are Being Misled

## A commentary on the campaign against Amendment One

*Ed. Note: This letter was submitted to the Denver Post and the Rocky Mountain News for use on their editorial pages. Though the election may well be over before you read this, we have reprinted it here for your information.*

A well financed and carefully orchestrated campaign, using frequent TV, radio and newspaper ads, vigorously attacks Amendment One, the proposal to increase the state tobacco tax 50 cents per pack of cigarettes and 50% of the price of chew, snuff and other tobacco products. Supported by the tobacco industry to the tune of nearly \$3 million, a hastily-contrived front operation, "Coloradans Against Tax Abuse and Government Waste," pays actors to tell you that a 50 cent tax increase on a package of cigarettes is both unnecessary and wasteful. The actors additionally question whether it's fair for a minority to be required to foot the bill for health, education and research programs that will benefit everyone. In these ads the message is repeated over and over that the State Health Department will receive huge sums of money which it can spend any way it wants. As usual, the tobacco industry is blatantly lying to the public in its effort to defeat an important health initiative in Colorado.

The facts are that the new revenues, estimated at \$130 million, will be specifically used in the following ways: 50% for the health care of people who need it but cannot afford it, 30% for school and

community programs to educate the public about the hazards of tobacco, 10% for research on tobacco-related illnesses aimed at prevention and cessation of tobacco use, 5% for economic development of small businesses whose activities are related to smoking cessation, 4% for distribution to counties and municipalities in the same manner that tobacco tax revenues are currently distributed and 1% for administration of the program. The passage of Amendment One will be a major step in reducing the premature suffering and death imposed upon smokers through tobacco addiction, because fewer people will pay the higher price for cigarettes and because the funds generated will enable people to be better educated regarding the harms of tobacco. The tobacco industry knew about the addicting nature of its products even before the first Surgeon General's Report in 1964. Nonetheless, they continue to deny this fact even while testifying - under oath - to Congress!

A key goal of the tobacco tax is to reduce smoking among teenagers. This has clearly been one result of California's Proposition 99, the 25 cent increase per pack of cigarettes which was passed by their legislature in 1988. If teenagers can be freed from their bondage to tobacco

*"Amendment 1...ensures that tobacco users take more responsibility for the cost of health care related to their tobacco use."*





*continued...*

*"Every time I see a teenager purchase a package of cigarettes, I feel both sorrow and anger."*

addiction - or better yet, never start using tobacco - Coloradans will bear a much smaller burden of tobacco-related health costs and lost productivity which today cost us 1.1 billion per year!

It is true that the legislature will not determine the use of funds generated by Amendment One. This is an advantage, a fact supported by three articles which appeared in the October 18, 1994 issue of the *Journal of the American Medical Association*. These articles demonstrate a strong link between tobacco campaign financing and pro-tobacco legislative action in the California legislature and in both houses of the United States Congress. As proposed by Amendment One, use of revenues from the new tobacco tax will be carefully controlled by an 11-member Citizens Commission to be appointed by the Governor. These individuals will be free from the influence that tobacco money brings. They will serve three year terms, just like members of the Transportation Commission.

The best way to improve the health of Coloradans is to stop tobacco use altogether. Why is the tobacco industry spending so much money in Colorado? The answer, I believe, is our positive attitude toward health and our high interest in education and research in pulmonary diseases, a tradition that began with the migration of patients with tuberculosis to Colorado at the turn of this century. Colorado has become an exemplary "healthy lung state." Thus, if the tobacco industry can win in Colorado, they will be encouraged to stop health care

initiatives elsewhere.

Now our greatest tobacco challenge is lung cancer, the most common fatal malignancy in both men and women in Colorado and the nation. The prevalence of this dreadful disease continues to rise in Colorado, along with heart attack, stroke, and chronic obstruction pulmonary disease (COPD), which are all related to tobacco use.

Every time I see a teenager purchase a package of cigarettes, I feel both sorrow and anger. These young people continue to be seduced into tobacco addiction by increasingly clever ad campaigns featuring characters like the Marlboro Man and Joe Camel. It's time to take tobacco to task! I earnestly hope that all voters, both smokers and nonsmokers, will see through the tobacco industry's irresponsible attack on Amendment One, an important health opportunity for Colorado.

*Thomas L. Petty, M.D.  
Professor of Medicine at the University of Colorado Health Sciences Center  
and  
President of Health One Center for Health Sciences Education.*

# THE CMS ALLIANCE



The Colorado Medical Society and the Colorado Medical Society Alliance are physicians and physicians' spouses. The Alliance assists the CMS in its programs to improve the quality of life... We're a team... or at least we should be... **One choice for membership at some level of involvement with the society and alliance.**

**One Voice to bridge relationships with legislators** to allow physicians to do what they do best — deliver the finest health care in the world.

**One voice to stop violence in America.** "27,000 people will die by homicide this year, 13,220 by handguns," says Robert McAfee, AMA President. "If you need a reason to be part of this team let me remind you, **there are more years of**

**life lost to violence in the United States of America than years of life lost to heart disease, cancer, and stroke combined," said Dr. McAfee. He went on to say "We the people of the United States...will allow more women to be killed in their homes by their husbands or boy-friends in slightly more than 10 years, than men died in the entire Vietnam War."**

Through our many and varied programs The Alliance can and does make a difference in our communities. We are "Physicians' spouses dedicated to the health of America." From our support of school based health clinics, to support of "The Conflict Center," to providing child care seats, to support of many "Safehouses," to writing, producing, and distributing pamphlets for

victims of domestic violence, to funding adolescent suicide prevention literature, to providing members with many interesting programs, to raising funds to support the AMA-ERF, the CMSA works hard to be a driving force for the health of Colorado.

Since we are a team, or together everyone affects membership, perhaps you can help by giving your spouse the gift of membership in The Alliance. It's time we put aside our differences and concentrate on what we have in common...A commitment to guard the future of medicine.

Thank you,

*Patti Brown, President  
Colorado Medical Society Alliance*

I am interested in membership in the \_\_\_\_\_ (county) alliance, the Colorado Medical Society Alliance (dues \$15), and the AMA Alliance (dues \$25). Please contact me with more information

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_

Send to: Patti Brown, 6865 W. Princeton Ave., Denver, CO 80235 (303) 988-0888



# X

# -RAY Operator Rules

Lynn Livingston, CMS Division of  
Health Care Policy

*New requirements must  
be met by January 1, 1996*

In accordance with Colorado Statutes 12-36-104(1)(a), C.R.S. (1985) and 12-36-202(1)(a), C.R.S. (1991) all unlicensed persons operating x-ray equipment must pass a limited scope exam. Proof of such passage must be kept on file in each physician's office. Below is more information about this requirement which must be met by January 1, 1996.

**Colorado State Board of Medical  
Examiners  
Rules and Regulations regarding  
education and training standards for  
unlicensed personnel exposing  
ionizing radiation**

Due to a variety of clinical situations in which diagnostic x-ray techniques are utilized outside the hospital setting, and given the various levels of training and experience which may be required of unlicensed personnel who operate x-ray equipment outside the hospital setting, the Board concludes that a uniform education and training curriculum is impractical, but **demonstrated competency is necessary to adequately protect the public health, safety and welfare.** Following consultation with the Colorado Medical Society, the Colorado Radiological Society, and licensed physicians as required by Section 12-36-202(2), C.R.S. (1991), the Board has determined that contribution to public protection can be achieved by requiring persons, not possessing a medical license, who operate machine sources of ionizing radiation or who administer such radiation to patients for diagnostic medical use, to demonstrate competency via satisfactory passage

of the limited scope examination administered by the American Registry of Radiologic Technologists ("ARRT"), or any other exam designated by the Board.

1. These rules and regulations apply to all unlicensed persons in medical settings other than hospitals and similar facilities licensed by the Department of Health pursuant to Section 25-1-107, C.R.S.
2. No physician shall allow any unlicensed person to operate a machine source of ionizing radiation or to administer such radiation to any patient for a diagnostic medical purpose unless such unlicensed person has met the requirements set forth herein.
3. All unlicensed medical personnel exposing ionizing radiation must:
  - a. be a minimum of 18 years of age; and
  - b. achieve a passing score on the examination for the limited scope of practice in radiography administered by the ARRT; or
  - c. achieve a passing score on an exam designated by the Board.
4. Written verification of satisfactory passage of the ARRT limited scope exam or such exam designated by the Board shall be maintained in each unlicensed person's employment record located at the employment site, and the original shall be maintained by the unlicensed person.
5. For purposes of this rule, a Radiologic Technologist who

# **Colorado State Board of Medical Examiners**

## **Rules and Regulations regarding education and training standards for unlicensed personnel exposing ionizing radiation**

has satisfactorily completed a course of instruction and has been certified by the ARRT shall be deemed to have met the training requirements established in subsection 3, above.

6. The Board shall determine the passing score for the examination, which score measures the level of minimum competency for persons who operate a machine source of ionizing radiation or who administer such radiation to any patient for diagnostic purposes.
7. These rules and regulations become effective January 1, 1996.

### **When will the exam be given?**

Exams are administered by ARRT on the first Thursdays in October, March and July at a single location in the state (most likely in the metro area). Additional sites will be considered.

### **How do I register for the exam?**

At the present time the BME is looking for a third party to handle the registration/exam/reporting process. This third party should be secured and a contact person in place by November 1. Registration deadlines for the March exam is in January, for the July exam is in May and for the October exam is in August. Please send a self-addressed stamped envelope to the Medical Board if you wish to receive information about registration when details are known. Registration information will also be passed along to CMS members via *Colorado Medicine*.

### **Where can I get the training I need to pass the exam?**

Most book stores stock or can

order the "Registry Review for Radiological Technologists." The book provides a review of necessary information, sample exam questions with detailed explanations of each answer along with references for additional information about different subjects covered on the exam. The book is self-paced, requires no classroom time and is said to be an adequate review for preparation for the limited scope exam. For those

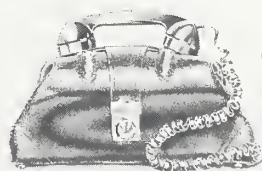
seeking additional training, several medical technologist schools have or are gearing up training and refresher programs. Send a separate self-addressed stamped envelope to the Medical Board for a list of those who have notified the Board that they have such a program.

Additional information is available to CMS members by contacting Suzanne Hamilton at the Colorado Medical Society.

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### Osteoporosis Awareness in 1994

*Paul D Miller, M.D., Clinical Professor of Medicine at the University of Colorado Health Sciences Center is President of the Metabolic Bone Disease Society of Colorado and International Society for Clinical Densitometry.*

The medical profession and the public alike have become increasingly aware of the bone disease, osteoporosis. This increased awareness is a result of several recent significant advances in this field:

1. Surveillance data indicate that the prevalence of osteoporosis-related bone fractures is increasing. It is currently estimated that 25 million Americans have osteoporotic fractures. The prevalence of osteoporotic fracture will double by the year 2020 and cost U.S. citizens and their insurance carriers over \$40 billion per year by that time. A portion of this increase is due to the longer lives enjoyed U.S. citizens.
2. Advances in diagnostic techniques, both radiological and biochemically, have enhanced the medical field of osteoporosis. The measurement of bone density, using bone densitometry,

allows the doctor to detect patients at high risk for osteoporosis-related bone fractures prior to the first fracture. In fact, bone densitometry can predict an individual patient's fracture risk *better* than cholesterol or blood pressure testing can predict heart attacks or stroke. Hence, patients can be diagnosed with osteoporosis *before* a fracture occurs. This early detection is important for two reasons. First, once an osteoporotic fracture occurs, the relative risk for a second fracture increases 25x in osteoporotic patients as compared to a 2.5 increased risk for fracture for each standard deviation reduction in bone mass in the osteoporotic patient without a fracture. Second, detection of high-risk populations allows selection of strategies to halt bone loss since fracture risk increases as bone mass decreases. Furthermore, bone densitometry and specific blood/urine tests can distinguish patients who are responding to treatment from those who are not. This capability is an exceptional new clinical tool in the practice of medicine.

Both the World Health Organization and the International Society for Clinical Densitometry have established clinical criteria for diagnostic thresholds in order to diagnose osteoporosis in frac-

tured or non-fractured patients. These include 1) normal, 2) low bone mass or osteopenia (1.0 to 2.5 SD below normal), 3) osteoporosis (2.5 to 3.5 SD below normal), and 4) severe osteoporosis (<3.5 SD below normal). These categories are based on decreasing levels of bone mass, with gradient reductions in bone mass being associated with increasing fracture risk.

3. Another major advancement is the development of new drugs which can prevent bone loss, and, in many cases, increase bone mass. The standard approaches to osteoporosis risk reduction include calcium, vitamin D, weight-bearing exercise, smoking and alcohol reduction, and estrogen replacement. Calcitonin, the biphosphonates and vitamin D analogues offer the clinician alternative medical interventions which can increase bone mass and reduce fracture risk.

Both men and women are experiencing an increased number of bone fractures due to osteoporosis. These fractures reduce life expectancy and the quality of life in those individuals who do survive. Early detection, early preventive intervention, and effective therapeutic treatment can reduce osteoporotic-related bone fractures and medical costs.



## Osteoporosis: The State Prevention Project

Richard C. Fisher, MD

Associate Professor of Orthopædics at the University of Colorado Health Sciences Center and  
Director of Orthopædics at Denver Health and Hospitals

Osteoporosis has become a national public health issue as our population ages, and it is a topic well known to the health care community. In Colorado, the facts attest to the significance of this problem. An estimated 400,000 women in Colorado over the age of 50 have an increased risk for osteoporosis. The hip fracture rate for people over age 65 is 878 per 100,000 per year, and increases to 4034 per 100,000 in women over 85. This translates to about 2,800 hip fractures per year in the state. In line with national trends, elderly hip fracture rates in Colorado have increased approximately 20% between 1989 and 1992. Public health officials are now recognizing the importance of health care providers in *prevention* as well as treatment of the disease.

In 1991, the Colorado Department of Health was awarded a three year grant from the Centers for Disease Control and Prevention to develop an osteoporosis prevention project within the state. The scope of this project included determining the prevalence of osteoporosis and its associated risk factors in Colorado, identification of local resources for treating osteoporosis, development of a statewide strategic plan for osteoporosis prevention, and the development and testing of educational interventions. The project is overseen by Nancy Henderson,

MSW, of the Division of Prevention Programs, and is under the guidance of an advisory committee composed of people experienced in nutrition, exercise, and occupational health, as well as nurses and physicians.

The project has recently completed its strategic plan, which is designed to provide a framework for an organized prevention effort in Colorado. Particular objectives for the prevention plan include the reduction of hip fractures, increased calcium intake and physical activity, and an increase in the number of perimenopausal women who have been counseled in the benefits and risks of estrogen replacement therapy. The means of accomplishing these objectives fall into the realm of public education, health care provider education and support, policy changes, and surveillance.

The surveillance program instituted as a part of this project has provided baseline data for the incidence of hip fractures and the prevalence of behavioral risk factors in the state. Additional studies will be done in order to further identify at-risk populations and to guide development of further prevention strategies. The measurements will be repeated in the future to monitor changes over time. A study of barriers to the use of postmenopausal estrogen among low income women is planned for 1995-1996.

*Osteoporosis has become a national public health issue.*

*continued on  
following page...*



# Osteoporosis

*from previous page...*

**For further information contact Nancy Henderson, at 303-692-2591.**

The project at this point is in the process of instituting the education programs outlined in the strategic plan. Because physicians, as well as physicians' assistants, physicians' office staff, nurses and nurse practitioners, are in a particularly influential position to implement prevention strategies and change individual behavior, the project is seeking to disseminate information to these professionals. A selection of professional and patient education materials is being offered at no charge as indicated below. Program support materials, including a slide presentation and videos for patient education

are available on loan. The project also offers assistance in arranging for program speakers.

This educational effort will require the cooperation of the extended family of health care providers within the state. It is hoped that some improvement in this disease will be seen as our population continues to age. For further information contact Nancy Henderson, Osteoporosis Prevention Project Coordinator, Colorado Department of Public Health and Environment/PPD-IP-A5, Denver CO 80222; phone number 303-692-2591; fax 303-782-0095. To request educational materials call 303-692-2586.

## Prevention Resources for Patients and Professionals

The following materials may be obtained by calling the Colorado Osteoporosis Prevention Project at 303-692-2586:

### For Patients/Office Staff/Community Education

1. A set of National Osteoporosis Foundation (NOF) reproducible information sheets for patients/community education. Includes all age groups.
2. NOF lecture/slide presentation, available on loan.
3. SMILE (So Much Improvement with a Little Exercise) videotape low-intensity exercise program for home or group use, available on loan.
4. Article for newsletters
5. National Osteoporosis Foundation catalog of educational materials.

### For Health Care Professionals

6. *Preventing Osteoporosis in Colorado 1994-2000*. Strategic plan developed by the Colorado Osteoporosis Prevention Advisory Committee containing an overview of the problem, state epidemiologic data, and prevention strategies for various population groups.
7. NOF information sheets. A set of consensus statements/information sheets on exercise, calcium, vitamin D, estrogens and hormone replacement, calcitonin, biphosphonates, fluoride, anabolic steroids.
8. "Consensus Development Conference: Prophylaxis and Treatment of Osteoporosis." Conference report, 1990.
9. *Osteoporosis: A Challenge for Today*—22 minute video cassette covering bone remodeling, risk factors, diagnosis, and treatment. Produced by Wyeth-Ayerst.
10. *Osteoporosis: Prevention and Treatment*—2 part video, 13 minutes each, Wyeth Ayerst.



## You can get Both Social Security and SSI

Most people are aware that individuals can receive Social Security benefits. Most people are aware that individuals can receive Supplemental Security Income (SSI) benefits. But many people may not know that under certain circumstances, individuals can get both Social Security and SSI benefits at the same time. Let me give you an example of how a person can get both Social Security and SSI benefits at the same time. I'll change the name of the person involved but use her case to explain the programs.

Helen Trump, a 65-year-old domestic worker, came in to file for her Social Security retirement benefits. Although she worked regularly for the past 40 years, she never earned much money and sometimes her employers failed to withhold and pay Social Security taxes for her. Those two factors coupled to make her Social Security benefit low—only \$366 per month.

In Helen's case, the Social Security claims representative talked to her about the SSI program. The representative explained that SSI pays individuals who are age 65 or older, or disabled individuals under age 65. In addition, to qualify for SSI, a person must have limited income and "resources." Resources are things like savings and checking accounts, bonds, and anything else that can be converted into cash. The home in which you live and the car you drive usually **do not** count as resources.

Helen's only income was her

\$366 Social Security check. (SSI considers her Social Security benefit "unearned" income). Helen rented a small apartment, had a small bank account and an old car. Since Helen had limited income and few resources, the claims representative immediately helped her file for Supplemental Security Income (SSI). As the name suggests, SSI is designed to "supplement" a person's income up to a certain level. Here in Colorado, an individual who has unearned income up to \$466 monthly limit can get SSI. (Some States add to the federal SSI payment level so payment levels may be higher in those States).

Now, Helen will receive two benefit checks every month — \$100 from SSI and \$366 from Social Security. Further, since Helen qualified for SSI, she can get Medicaid which will supplement her Medicare coverage. Even if she did not get Medicaid, the State may pay her Medicare premiums and other Medicare costs through the "Qualified Medicare Beneficiary (QMB) program.

(NOTE: To simplify the example in this article, we added the \$20 "disregard" to the SSI limit).

(Note: If you hire someone to clean your house, work in your garden, etc., you are legally required to pay Social Security taxes for the person. Otherwise, that person will probably face the same situation as Helen Trump — years of hard work and a low retirement benefit that does not reflect the true earnings).

*by Tom Przytarski  
Social Security Manager  
in Denver*





### McCartney re-elected to ASIM Board



**Robert D. McCartney, MD**, a Denver internist with a special interest in geriatric care was re-elected as a trustee of the American Society of Internal Medicine (ASIM) at that group's 38th Annual Meeting recently.

A 14 year member of the Colorado Medical Society, Dr. McCartney currently chairs the CMS Health Affairs Council. He is past president of the Colorado Society of Internal Medicine and in 1992, he served on the Task Force on ColoradoCare. He has been active on a national level in Medicare issues.

He chairs the board of Denver Health and Hospitals and is active in Physicians for Social Responsibility, the World Congress of International Physicians for Prevention of Nuclear War and the Colorado Coalition for the Homeless. He is also a fellow of the American College of Physicians and a member of the American Medical Directors Association.

### Overcoming Barriers to Immunizing Two Year Olds

*by Paul Melinkovich, MD*

*Associate Director*

*Community Health Services, Denver*

*Department of Health and Hospitals*

Childhood immunizations continue to be a much discussed topic among physicians, public policy makers, legislators and the President. In 1993, Congress passed legislation creating the Vaccine for Children (VFC) Program that was implemented on October 1, 1994.

The VFC Program was created to reduce financial barriers to vaccine for low income children. These and other actions were prompted by the measles epidemic that occurred between 1989 and 1991, and reminded health professionals and public health leaders about the need to maintain adequate immunization levels among susceptible children. Attack rates during that epidemic were very high in communities with low immunization rates among infants and preschool children. During the epidemic, there were more than 55,000 cases of measles resulting in 11,260 hospitalizations and 150 deaths.

In response to the measles epidemic, the National Vaccine Advisory Committee (NVAC) was constituted by the Centers for Disease Control (CDC), with their first task being an analysis of issues contributing to the epidemic. The

NVAC concluded that there were multiple contributing issues, including problems with vaccine availability and accessibility, public complacency about vaccine preventable diseases, barriers to health care access, financial barriers to vaccines, and problems with provider practices<sup>1</sup>. Although most of the infants and children infected by measles were not immunized, many had been recently seen in a health care setting and could have been immunized. As a result of the analysis, the NVAC issued the Standards of Pediatric Immunization Practices, a document supported by the American Academy of Pediatrics, the American Academy of Family Practitioners, and numerous other professional associations. The Standards recommend numerous other professional associations. The Standards recommend numerous strategies to address barriers, such as: changes in provider practices to avoid "missed opportunities" to vaccinate children in health care settings; regular assessment of the immunization levels of clinic users; and the establishment of tracking and recall systems to remind patients of needed vaccines<sup>2</sup>.

Subsequent to the development of these recommendations, a number of researchers have examined the practices of primary care practitioners and their relationship to preschool immunization levels. Findings from these studies demonstrate that provider practices vary considerably and that a number of the recommendations of the NVAC are not routinely practiced<sup>3</sup>. In particular, the administration of vaccines during all



health care visits, including acute care and follow-up visits, is a practice that many clinicians do not follow. Another consistent finding of these reports is that physicians often overestimate the level of immunizations in their practices and that levels are lower than CDC standards<sup>4</sup>. Findings from practice assessments in Colorado, both in public and private settings, also demonstrate that levels for 24 month old children lag behind national goals.

As part of the Federal response to the measles epidemic, the Immunization Program at the Colorado Department of Health (CDH) has received increased funding to improve preschool immunization levels. This funding supports outreach activities in local communities to reach high risk children in need of vaccine. In addition, it supports disease surveillance activities and immunization assessment activities to determine preschool immunization rates. Baseline audits have been performed in all of the public health clinics in the state and demonstrate percentages of children who are fully immunized by 24 months of age that range from 36% to 93%. Few audits of private offices are available, but those that have been conducted show rates ranging from 34% to 84%. Most sites, private and public, are well below the 1996 CDC goal of 90% fully immunized by 24 months of age. The State Health Department has received additional funding this year to assess immunization levels in the private setting and is interested in identifying potential practices. Since more than 70% of the childhood vaccines administered

in Colorado are done in the private setting, assessments of private practices are an important measure of Colorado childhood vaccine levels. In addition to assessments, the Colorado Department of Health has developed inservice programs for physicians, nurses and office staff about immunization schedules; vaccine handling, storage and delivery; and vaccine liability. Numerous changes in vaccine schedules and products plus changes in informed consent required by the National Childhood Vaccine Injury Act have occurred during the past year. Materials about new recommendations and consent standards are available from the State Health Immunization Program. In addition, inservices to staff may be available as needed. Anyone interested in these materials or in having their practice anonymously audited should contact Lori Quick, RN, the Immunization Assessment Coordinator at CDH, at (303) 692-2794

<sup>1</sup> Orenstein, WA, W. Atkinson, D

Mason, et al. *Barriers to vaccinating preschool children. J Health Care Poor Underserved* 1990; 1:315-333.

<sup>2</sup> National Vaccine Advisory Committee. *The measles epidemic: the problems, barriers, and recommendations. JAMA* 1991; 266:1547-1552.

<sup>3</sup> Szilagyi P, L Rodewald, S Humiston, et al. *Missed opportunities for childhood vaccinations in office practices and the effect on vaccination status. Peds* 1993; 91:1-7.

<sup>4</sup> Szilagyi, P, K Roghmann, J Campbell, et al. *Immunization practices of primary care practitioners and their relation to immunization levels. Arch Pediatr Adolesc Med* 1994; 148:158-166.

## OSHA Ups Ante For Willful Violators

In June, OSHA announced a fivefold increase in the minimum penalty for willful violations of federal safety rules that could result in death or serious physical harm. The new minimum penalty for these so-called "willful serious" violations will be \$25,000.

The maximum penalty remains \$70,000 for such violations. Employers with 25 or fewer employees could have penalties reduced by as much as 30% just for being small and an additional 10% for a good safety record.

OSHA defines a willful violation as one in which the employer knew that a hazardous condition existed and made no effort to correct it. A serious violation is one in which there is a good chance of serious injury or death.

(The information above was reprinted with permission from the *Bloodborne Pathogen Update*, David Hustvedt, Editor, 967 Poorman Road, Boulder, Colorado 80302. 800-334-1213)





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1/1194





## RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

*Assistant Editor's Note: Our esteemed editor, Mr. Pierson, has gone off on a tour of Europe with his lovely wife Ann. While, of course, we hope they are having a wonderful time, Bill did not turn in his regular "Ruminations" column before he left. However, this drawing from The New Yorker magazine may provide us with evidence of his activities since he left Colorado. Let us hope he has not embarrassed us by ruminating in front of the Europeans.*



*"I caught this guy ruminating in public."*

Drawing by D. Reilly; © 1994  
The New Yorker Magazine, Inc.



# STACKS COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

October, 1994

Volume 91, Number 12



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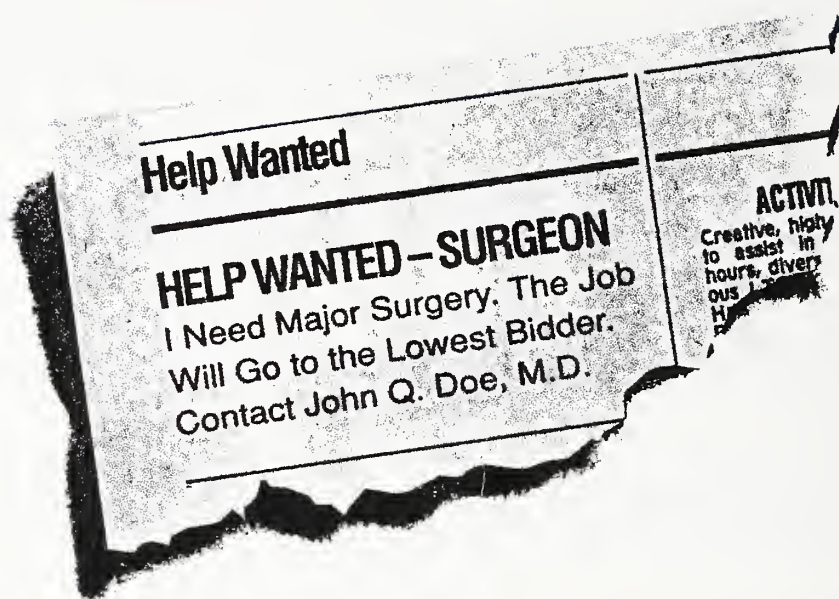
See **PRESIDENT'S LETTER** (Page 415 and following)

This Issue:

- Network Plan Modified** ..... Page 415ff  
**What Does the CMS Membership Look Like?** ..... Page 422  
**Interim Meeting 1995: Preliminary Information is Out** ..... Page 426

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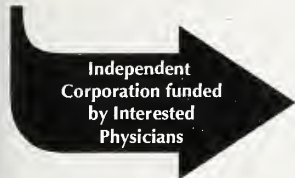
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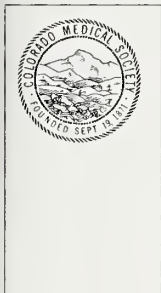
December, 1994

Volume 91, Number 12



## Cover Story

As CMS President David Martz says, it's the member's choice, and Colorado Physician's Network moves closer to reality.



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# Colorado Medicine

## Cumulative Index

### Volume 91, 1994

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# Good Service

is a rare and valued commodity in today's world, yet something that's just part of everyday life for a physician. Providing good medical care and serving their communities is what physicians are all about.

Once in a while, though, there is the physician who stands out from the pack; the one who goes above and beyond the call of duty, even for a caring professional. These admirable individuals tend to avoid the spotlight and the majority of us never hear of their laudable activities.

Often, though, their peers notice something special and wish there was some way that person could be honored for this extraordinary level of service.

The Colorado Medical Society provides two such ways. One is the Certificate of Service, awarded at each Annual Session of the House of Delegates to a physician who does the most to further the constitutional purposes of the Colorado Medical Society in advocating excellence in the provision of health care for the people of Colorado.

The other is the Wyeth-Ayerst Physician Community Service Award (formerly the A. H. Robins Award in honor of their founder). This award is given to the physician who demonstrates excellence in service to the community as a whole, in addition to commendable medical practice.

Each spring, the calls for nominations for these awards are published in *Colorado Medicine*. Be thinking now who you might like to nominate and begin the discussions within your component society that could lead to such a nomination.

## PRESIDENT'S LETTER



David C. Martz, MD  
President, 1994-1995

After about two years of preliminary exploration by the Network Task Force, a CMS physician survey conducted by Monaghan and Associates, and a near-unanimous vote by the House of Delegates to proceed with the feasibility study to be financed by a mandatory \$100 per member assessment, the CMS Board of Directors on Friday, November 18 voted to modify the approach to a statewide physician network in the following ways:

- The \$100 fee will be voluntary rather than mandatory.
- Those who choose not to contribute their \$100—or to have their already paid \$100 refunded to them—will NOT have to resign from CMS.
- If the project remains feasible after all funds are collected or retained, a corporation distinct from CMS will be formed and will proceed with selection of a consultant, establishment of a governance board, and clarification of the ultimate structure of the corporation. (Whether this will consist of linking up existing IPAs, growing a single existing HMO to statewide proportions, co-partnering with an existing insurance company, or other potential strategies, will depend on the advice of the consultant to be named and the vision of the transitional leadership.)

The decision of the Board of Directors to modify the feasibility study assessment from mandatory to voluntary was based on the following observations:

- Over 2,000 of you have already

paid the \$100. We recognize that some have done so out of support for the physician network concept, whereas others have merely complied as loyal CMS members regardless of the level of interest in the Colorado Physician Network.

- Should even 10% of you feel so strongly against the assessment that you would prefer to quit CMS than pay the \$100, it would severely cripple CMS at a time when unity is essential. 90% accord on such a complex issue is beyond reality at this time.
- Reasons leading to nonpayment thus far may include:
  - \* Mechanical factors such as oversight, procrastination, timing of bill-paying, etc.
  - \* Lack of sufficient definition of the potential network structure to capture your interest.
  - \* The fear that physician-led business ventures are doomed to fail (à la the CMS building project of years gone by), notwithstanding the remarkable success of such physician-led ventures as Copic and the Rocky Mountain HMO.
  - \* The concern that a CMS sponsored statewide network would be crippled by having to impanel "any willing member" regardless of credentials or performance. (In fact, creating a physician network as an entity separate from CMS would allow it to function much as Copic does in this regard — CMS membership provides opportunity but not entitlement to participate.).
  - \* The apprehension that the network

(Continued on following page)

**Colorado Physician  
Network LIVES!**  
*...but the game plan  
has changed*





## PRESIDENT'S LETTER (Continued)

would compete adversely with managed care plans already committed to by some of our membership.

- \* The belief that it is "too little, too late" in a state already heavily penetrated by managed care; or that CMS should stay out of facilitating any business venture.
- \* The resistance to "mandate" in any form.

There may be other valid reasons not listed above, but the bottom line is the same: we hear your concerns and we will not risk the stability of CMS if 90% of you are not convinced that the physician network is feasible for you. Conversely, there are many of you who eagerly

embrace the concept, and we would be derelict to abandon it merely because it does not appeal to everyone.

So we have elected to make it voluntary and to allow you to choose if you wish to leave (or send) your \$100 in the pot; if not, we will cheerfully return (or not expect) your \$100 as an indication of your non-requirement for this particular effort by CMS. **YOU WILL NOT BE EXPELLED FROM CMS...** We will not, however, roll your contribution over into the corporation nest egg without your specific permission. All contributors are being notified, by certified mail that includes a self-addressed response indicator, of the option to stay in or drop out.

It is our belief that the majority

of you who have already contributed will elect to "stay in". If not, we will (regretfully) send ALL the money back, terminate the network effort, and move on to other activities on your behalf.

Your leadership has learned a great deal in the past few months. Your response to the network feasibility assessment has demonstrated how challenging it is to envision possible solutions to complex problems and to communicate this adequately to our entire membership. CMS will continue to move forward on your behalf in the months ahead.

# LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.  
Denver, Colorado  
(303) 861-1000

## Hiring the Right Lawyer for You

Physicians are understandably concerned about the question of how to select the right attorney for his or her practice and personal matters. Because of legal malpractice suits, the cost of legal services, and the often competitive aspects of the medical and legal professions, many physicians are at a loss as to those matters which should be considered and evaluated when deciding to employ an attorney. These same issues are confronted by the public when attempting to determine which physician to utilize for wellness exams, as well as for major treatment intervention because of a potential life threatening disease. Here are the most significant issues for your consideration in engaging an attorney for business or personal matters:

1. Is the charge per hour excessive? An extremely competent attorney who charges \$215.00 per hour is much less expensive than a mediocre attorney who charges \$150.00 per hour but takes two hours to accomplish what the well qualified attorney can accomplish in one hour.
2. Is the attorney honest and is the work professionally performed? Integrity and quality of work can be verified through references.
3. Is the attorney willing to use his business contacts to aid you in getting more favorable insurance quotes, more favorable banking relationships, less expensive and more comprehensive accounting representation, etc.?
4. Does the attorney's law firm have sufficient capacity to meet most of your needs, i.e., pension and profit sharing and tax matters, collection of accounts receivable, maintenance of corporate formalities, litigation support, risk management analysis, etc.?
5. Is the attorney knowledgeable concerning your particular practice, from a medical and business standpoint. Without such knowledge and understanding, it is unlikely that the attorney will be able to anticipate your legal needs.

6. Does your attorney practice law because it is a medium for making a good living or does he or she practice law because he or she enjoys the work and challenge and feels a sense of accomplishment when rendering professional services to clients? The attorney who practices exclusively for the money, rather than for the other reasons, will probably be unavailable when you need him or her the most.
7. Does your attorney have business experience, background and training? Many attorneys graduate from law school and begin employment with a law firm having had no business experience. These same individuals often do not serve on business boards nor do they involve themselves with the day-to-day business operations of their own law firms. Without a modicum of understanding of how a business operates, as well as the financial and employment issues associated with the operation of a business, it is unlikely that the law firm seeking to represent you will be able to anticipate or understand your business needs.
8. Does your attorney display common sense and creativity when having discussions with him or her concerning your business and personal matters? If the attorney relates to you only what the law mandates, you are probably lacking the second component of every meaningful attorney-client relationship. The first component is providing professional, timely, and quality legal services. The second component is an attorney acting as a "counselor" in addition to a legal advisor.

The attorney-client relationship is one predicated on trust and confidence. The selection of the right attorney for you is one of the most important business decisions and personal decisions you will ever make.

## EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney  
Executive Director  
Colorado Medical Society

**Believe it or not, CMS works hard** to create internal and external cohesion.

CMS faces a great challenge - the fragmented structure of the professional community. The multiplicity of groups and associations in the physician community seriously complicates the traditional role of CMS as the voice for members. For physicians, the issue of managing relationships among all the various county, state and national associations, PHOs, IPAs, etc., is a key strategic issue.

At the September, 1994 Annual Meeting, the House of Delegates overwhelmingly adopted a resolution which called for CMS to study whether a statewide physician network should be created. The funding for this feasibility study was to come from a mandatory \$100 assessment levied on each member, excluding medical students, residents, and emeritus members.

The initial assessment notice was mailed on September 30, 1994. The phone started ringing on October 1, 1994. Most people do not call to express support but to express concern. The phone calls were not pleasant, and it was clear that a portion of the membership was angry.

Was the anger over the fact that the assessment was mandatory? Was the anger related to the perception that this statewide network could be in direct competition with local networks? Was the anger related to the fact that the entire membership was not polled? Was it a control issue? It could be all of the above plus several other miscella-

neous reasons. Something wasn't right.

CMS leadership carried out the wishes of the House of Delegates, delegates who were volunteering their time to represent the views of their constituents.

As of November 21, only 54% of the membership had paid the assessment. Does this mean that the other 46% does not support the project? We will likely never know. Although the project is not dead, the Board has voted to change the assessment to a voluntary contribution. Please read the President's Letter in this issue. Also, watch your mail for details.

What could we have done differently? Does the fact that the views of membership and the House of Delegates significantly differ on this subject tell us that we need to modify the way in which CMS establishes policy? Is the practice of medicine becoming so competitive that we can't trust one another? Do you not believe that CMS has your best interest at heart?

As members of CMS, it is up to you to answer these questions. I look forward to hearing from you.

In light of all that is changing around us, we still have a lot to be thankful for.

Sincerely,  
Sandra L. Maloney

*The Colorado Medical Society (CMS) was created to formulate strategy and policy on behalf of individual members.*



# **S**tatewide Physician Network Plan Modified

*It was intended to be a positive alternative to help physicians cope more effectively with the onslaught of health care reform and managed care by taking control of their own organization.*

(November 18, 1994) The Colorado Medical Society Board of Directors in a marathon session today modified plans for a statewide physician-directed health care network. CMS President David C. Martz, MD told the Board there was not a "favorable vote" from CMS members in favor of the society going forward with a feasibility study to determine if CMS should sponsor such a network.

Only 53% of the active members of the CMS had complied with the House of Delegates' deadline of November 15 in responding to the assessment to fund the feasibility study of the network. The Board, responding to advice from the executive committee, felt that this low response rate indicated that CMS members were not in strong support of the idea, thereby reducing the chances of success.

Dr. Martz told the Board members that there were several possible reasons why 47% of the membership did not respond. They might merely be slow in processing their mail. They might be opposed to the idea and not want to fund it, or they might desire more information before responding. There were some negative responses received which indicated opposition to the project. It is not known how statistically representative they are of the general membership, but if their numbers are any indication, a significant minority of CMS physicians do not support the idea of a CMS sponsored physician network.

Dr. Martz, CMS President-Elect Joel M. Karlin, MD, the Executive Committee and the Board of Directors all agreed that it was not the

intention of the House of Delegates to alienate a significant portion of the membership with this idea. It was intended to be a positive alternative to help physicians cope more effectively with the onslaught of health care reform and managed care by taking control of their own organization. If a large percentage of the membership does not like the idea, then it would not be in the best interests of the society to continue with it.

Two basic issues are involved here. One is a concern raised by some Board members that the House of Delegates, at least on this issue, was not representative of the membership as a whole. The second may be a contributing factor in that. It was the observation by several at the meeting that the more information a physician had about the network, the more likely that person was to support it. As the House of Delegates and the Board of Directors had seen presentations and received much information, they were more likely to be in favor of the idea, while the membership, receiving only the results of those deliberations through *Colorado Medicine* and mailings (see sidebar) may not have fully understood the concept and were therefore not as strongly supportive.

This lack of information was illustrated by some of the negative responses to the assessment letter, which stated opposition to certain ideas which had not been proposed. The feasibility study is a prime example. It was intended to determine, by market analysis and other means, exactly what kind of network would be most likely to succeed in

# Assessment no longer mandatory

by Michael P. Thompson  
Assistant Managing Editor

Colorado's health care marketplace. Therefore, the structure of the proposed network could not be set until the study was completed and if a suitable structure could not be determined, the idea would be dropped. Yet many physicians wanted to see specifics on the structure of the network before they would support the feasibility study, while others opposed CMS getting involved in specific types of managed care organizations despite the fact that nothing specific had been proposed.

Taking all this into account, the Board felt that there was not enough positive support for the idea, and indeed, going ahead with the proposal had a significant likelihood of alienating a portion of the membership, despite its other obvious advantages. Several ideas were proposed as solutions to this problem, which the Board long discussed before arriving at a compromise plan.

A certified letter will be sent to all active members (those who were *required* to pay the assessment by the House of Delegates) informing them that the **assessment is no longer mandatory**. If physicians request, they may receive a refund of their \$100. However, if they desire, the money will be put into a new corporation, formed by the medical society and overseen (at least initially) by a few CMS members. This new corporation will independently form a statewide physician directed health care network, if feasible. This means that no physician will face loss of CMS membership over the question of this assessment.

If too many CMS physicians request a refund of their \$100 and there is not enough left to successfully fund the project, it is likely that all money will be returned. It is felt, however, that there was enough interest in the idea to make a voluntary network possible. In fact, it has been stated by several members that abandoning the project entirely

would betray those who had willingly participated.

Dr. Martz strongly urged all Board members to talk with their component society members to make sure there is a clear understanding of the entire issue. The Board wants to move forward in a positive way, but not against the wishes of the members.

*The idea of a statewide physician network has been under consideration in the Colorado Medical Society for more than a year now, beginning with seeds planted by then President Leigh Truitt, MD, carried on by his successors, Wm. Carl Bailey, MD and David C. Martz, MD. It has been discussed at virtually every meeting of the Board of Directors for the past year and a half and was the subject of resolutions passed by the 220+ representatives from all segments of the CMS in the House of Delegates at their past three meetings. Here is a chronology of events connected with the network:*

September 1, 1993	Colorado Medical Society President Leigh Truitt, MD explains concept of statewide IPA to all members in <i>Colorado Medicine</i> magazine.
September 9, 1993	Board of Directors submits Late Resolution 44A to House of Delegates proposing CMS sponsorship of a statewide IPA
September 12, 1993	House of Delegates approves Resolution 44A, broadened to include other physician-directed managed care organizations. Creates Task Force to report to Interim Meeting 1994.
October 1, 1993	<i>Colorado Medicine</i> reports creation of IPA Task Force and beginning of study of statewide IPA.
November 1, 1993	CMS President Wm. Carl Bailey, MD, writing in <i>Colorado Medicine</i> , lauds proactive direction of 1993 Annual Meeting, which includes creation of IPA Task Force.
November 19, 1993	Board of Directors approves makeup of IPA Task Force
January 28, 1994	Board of Directors approves submitting a Resolution to the House of Delegates authorizing a scientific study of CMS members to determine support for concept of statewide IPA. Authorizes additional members of IPA Task Force

*Continues on following page...*



# Network Chronology

February 1, 1994	<i>Colorado Medicine</i> notifies all CMS members that a Washington state expert in health reform by physicians will explain principles of similar network being formed by Washington State Medical Association. Publishes article by two attorneys giving background information on Integrated Delivery Systems.
February 17, 1994	Special mailing goes out to House of Delegates members explaining CMS sponsorship of a physician network, including articles and other background material on physician networks, summary of what other state medical societies are doing, and a progress report from the IPA Task Force.
March 5, 1994	Dr. Richard W. Seaman, past president of Washington State Medical Association addresses General Membership Meeting, explaining WSMA's Certified Health Plan and how Colorado can learn from it in forming a statewide physician network. Presentation by CMS leadership and staff regarding network activities in other states and explanation of the CMS network concept and activities.
March 6, 1994	House of Delegates approves Resolution 13A, authorizing \$30,000 for scientific survey to determine level of member support for statewide physician-directed health care organization.
April 1, 1994	<i>Colorado Medicine</i> reports passage of Resolution 13A to all CMS physician members.
May 1, 1994	<i>Colorado Medicine</i> devotes two pages to informing all CMS physician members of the task force's activities and the issues involved in forming a statewide physician network.
May 13, 1994	Board of Directors allocates \$30,000 as authorized by House of Delegates to fund survey regarding member support of statewide IPA. Changes name of IPA Task Force to Network Task Force, broadening scope of possibilities for proposed physician organization. President-Elect David Martz, MD holds planning conference on health reform issues, including how CMS can cope with changing times.
June 7, 1994	Network Task Force works to increase number of physicians responding to membership survey. Proposes mission statement, goals and objectives for physician-directed network.
July 11, 1994	Network Task Force receives preliminary results of member survey showing strong support for CMS action of some sort, but uncertainty as to nature of action. Decides to advocate unique health care organization, not HMO, IPA, PPO or anything else currently in existence. Finalizes mission statement, goals and objectives for physician-directed network.
August 18, 1994	Special mailing goes out to members of the House of Delegates representing all segments of the CMS membership regarding proposed Network Feasibility Study. Includes explanatory letter from CMS President Wm. Carl Bailey, MD, copy of proposed Resolution, draft budget for feasibility study, Network Task Force Progress Report and executive summary of membership survey just concluded. As representatives, Delegates should be sharing this information with their constituents in component and specialty societies.

*continued...*

September 1, 1994	CMS efforts to establish a statewide physician network are highlighted in two page cover story in <i>Colorado Medicine</i> .
September 8, 1994	Board of Directors submits Late Resolution 76A to House of Delegates, specifying goals for physician-directed health care organization and authorizing \$50 - \$100 per member assessment for feasibility study to determine what kind of an organization would be marketable and how to structure it.
September 9, 1994	Delegates receive reports from scientific survey of 373 members and chair of Network Task Force regarding workability of network and levels of member support for various options. Also receives information on similar efforts in other states. Reference Committee hears testimony from representatives of CMS members.
September 11, 1994	House of Delegates overwhelmingly approves Resolution 76A, setting assessment at \$100 and allowing for special designation of funds in cases of conflict with employment.
September 23, 1994	Information packet is mailed to all CMS members regarding network efforts to date and requesting payment of assessment by October 15, 1994 to avoid doing "too little too late". Packet includes recorded message from CMS President David C. Martz, MD explaining rationale of Board of Directors and House of Delegates in moving ahead with this project.
October 1, 1994	CMS President David C. Martz, MD explains current concepts involved in formation of statewide physician network in <i>Colorado Medicine</i> . Full page fact sheet on network is published in <i>Colorado Medicine</i> along with report on the passage of Resolution 76A by more than 200 delegates representing all segments of the Colorado Medical Society.
October 21, 1994	Second letter is mailed to all members who have not yet responded to first notice, again explaining the need for the project and urgency of quick action.
October 28, 1994	Board of Directors expresses concern over low member participation in assessment. Examines options to increase member understanding of feasibility study.
November 1, 1994	Follow-up article in <i>Colorado Medicine</i> encourages physicians to respond to second notice, stressing desire not to be an "also ran" in the changing arena of medical care. CMS President David C. Martz, MD notes in his <i>President's Letter</i> that leadership has been presenting information on proposed feasibility study to physicians around the state.
November 9, 1994	CMS Executive Committee determines based on current figures of compliance with assessment that proposed network does not have enough member support to be feasible. Recommends that Board of Directors modify plans.
November 18, 1994	Board of Directors agrees that House of Delegates action was not fully supported by the membership and does not wish to divide the society. Accompanying story explains current plans.





# napshots:

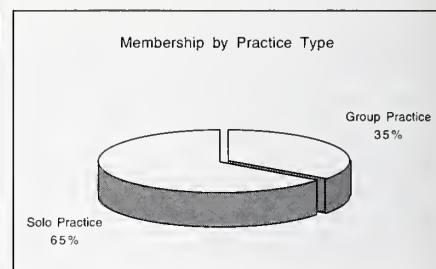
## Colorado Medical Society Membership

by Bill Pierson, Director  
Communications & Member Services

**Snapshots:** Colorado  
Medical Society Members  
...what do they look like?  
What do they do?  
Where've they been?  
Where'd they come from?

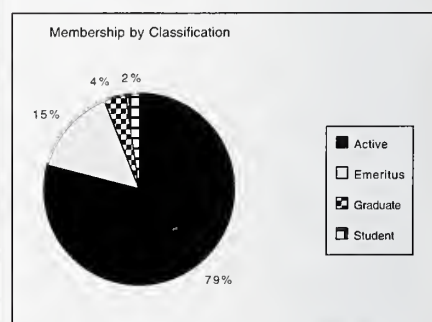
A photo won't tell you everything, but snapshots provide some interesting facts. Even word pictures help. For instance, the Colorado Medical Society active membership is 86% male with the majority between the ages of 36 and 50, who have been members of CMS less than 10 years. Of the 14% female membership, the majority has been a member of CMS fewer than 10 years. Their average age is between 30 and 45 years.

The largest percentage of CMS members (510) are in two-physician practices, nearly 400 in three-



physician groups, and the rest in four through twenty-member group practices almost exponentially. Group practice accounts for 35% of CMS membership.

54% of CMS members practice in metropolitan Denver while 10% are in eastern rural Colorado and 4% in western rural Colorado. 15% are in the southern front range area, while 17% are north of Denver along the front range.



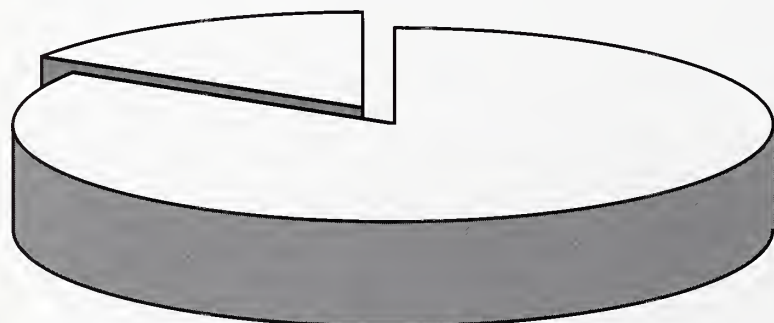
79% of our members are classified as Active, while 15% are Emeritus, 4% are Graduate and 2% are Students.

Among resident members, 30% are female. Among student members, 49% are female.

What else can be gleaned from these snapshots? For one thing, CMS membership is greater now than ever

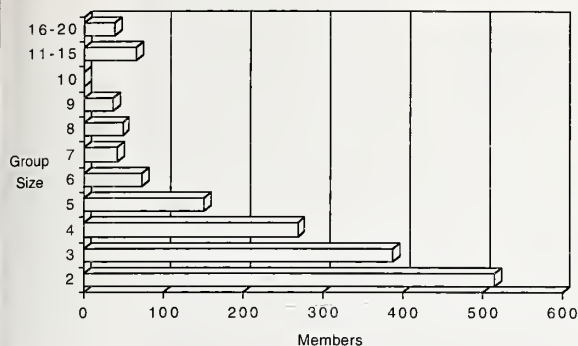
Membership by Gender  
All Members

Female  
14%



Male  
86%

Members in Group Practices



Why? Probably because someone at Colorado Medical Society got around to asking Residents and Students to become a part of the movement. I say that in only a somewhat facetious manner because I have actually heard from a Resident that no one had ever suggested he join CMS. CMS now has very active and

before. For another, Emeritus membership has swollen in the past five years to nearly 750. Meaning: the greater the number of assaults on medical practice from without, the greater the number of physicians who seek the help and comfort of organized medicine. At the same time the number of physicians moving away from full-time practice has been increasing.

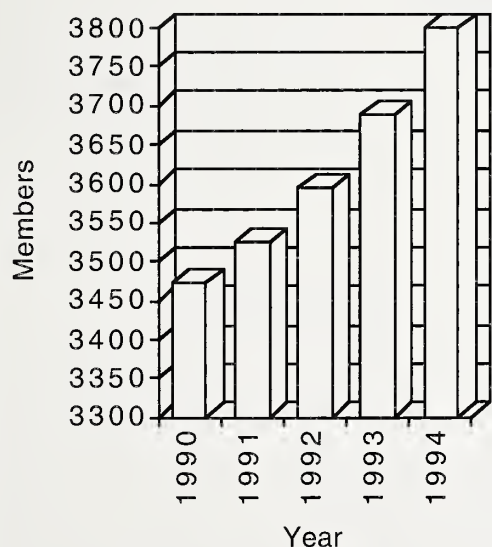
Also, this photo shows us a large increase in both Resident and

productive Student component society Due to the fact that young physicians have been organized and extremely active during this period, Colorado Medical Society can boast of greater participation by those physicians between 30 and 45 years of age.

So, even a word picture can show many things, particularly about a group of people of like or common interests and pursuit.

I have to say, as a personal, non-physician observation, that CMS has developed a very caring attitude about these people, not just expressed in member services, but expressed through services for the individual's needs, i.e., legislative, socioeconomic and communication programs which better fit the needs and expectations of the members, development of a more proactive organizational bent in behalf of its members. This capacity or bias has extended from the House of

Active



Student members in that same five year period. Resident membership has more than doubled, and Student membership has more than tripled.

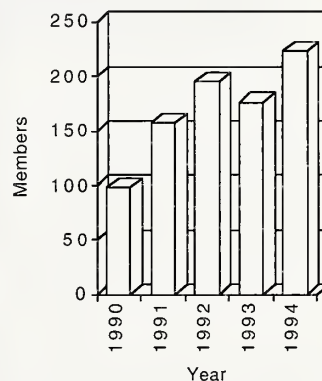
Delegates through the Presidency, the officers and the executive offices all the way to the department staff persons.

See the following page for charts on CMS membership tenure.

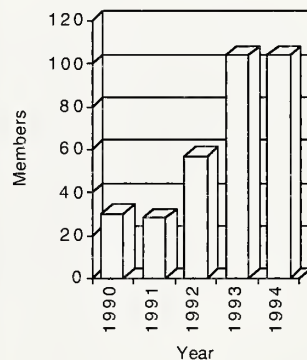
Our snapshots show that the Colorado Medical Society is a healthy organization and will continue as such for as long as any of us can foresee.

*Membership growth by "other than active" classification has also been strong.*

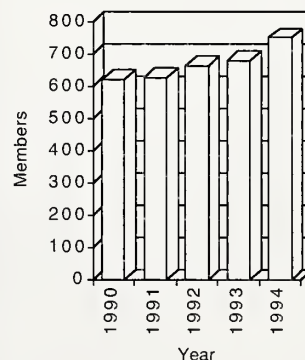
Residents



Students



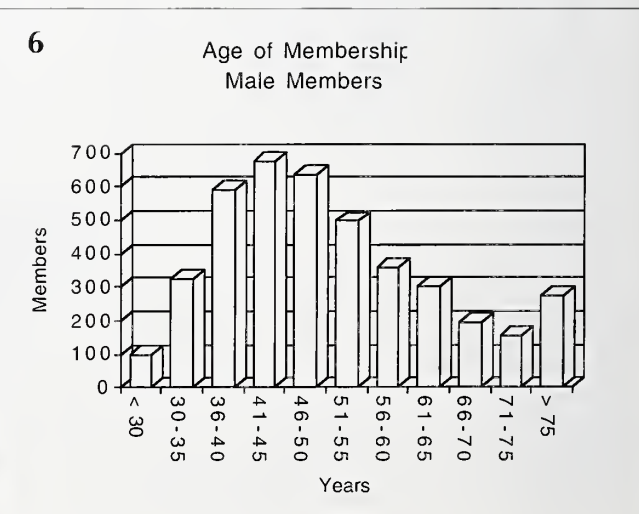
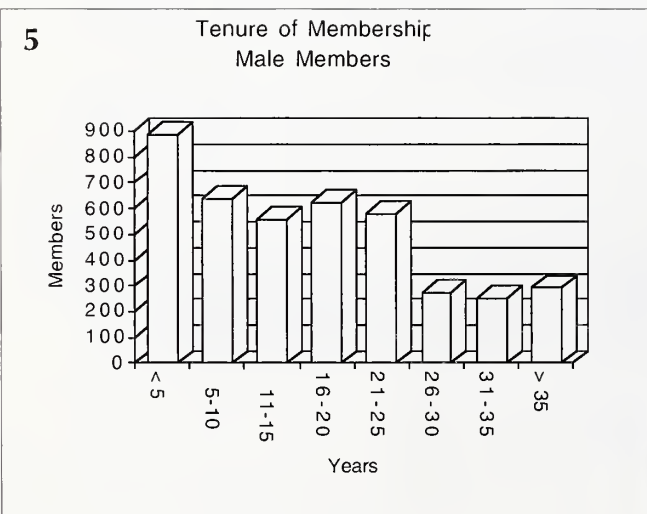
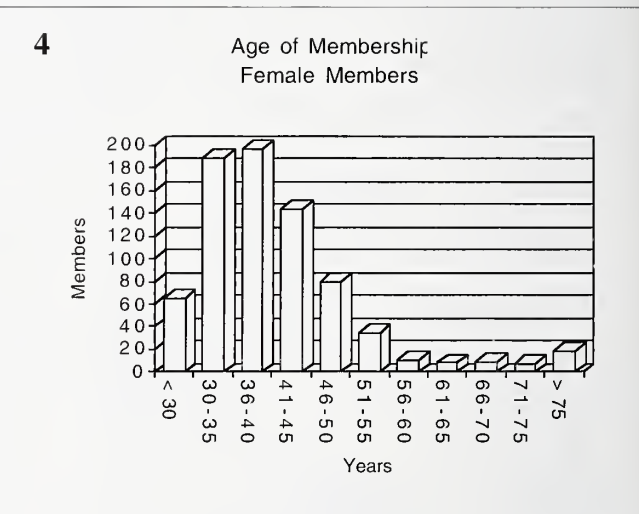
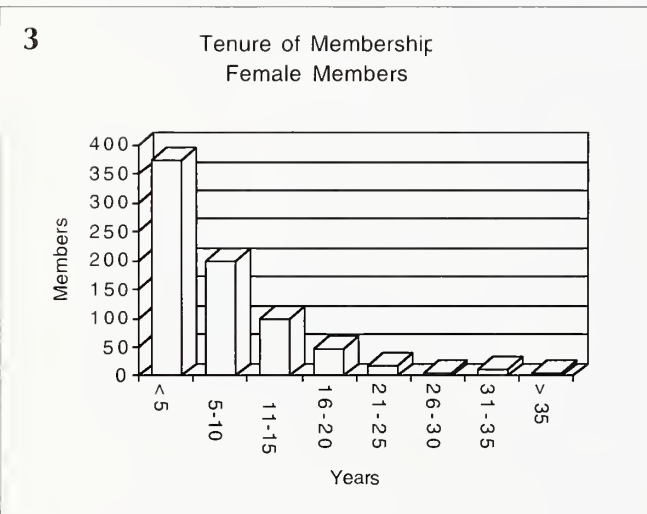
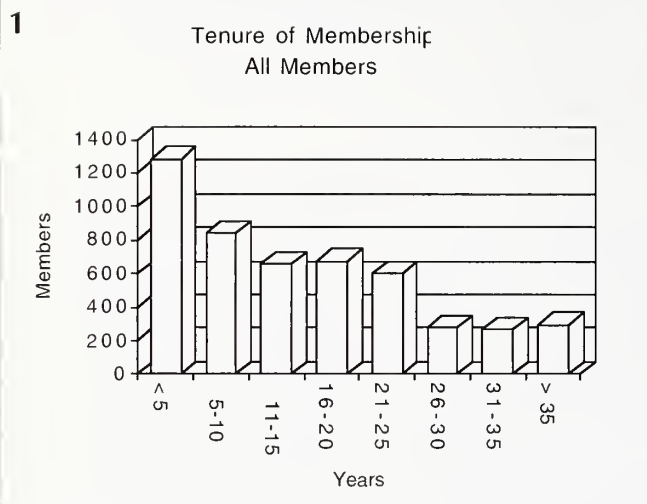
Emeritus





# Tenure . . . Some have it and some don't.

More than half of Colorado Medical Society's members are male between the age of 35 and 50 (Chart 2), 20% of whom have been CMS members fewer than five years (Chart 5). 60% have been members between five and 25 years (Chart 5). The majority of the female membership have been active in organized medicine fewer than five years (Chart 3).





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- Offer valid on rentals of 5 to 14 days.
- Only one certificate per rental, not to be used in conjunction with any other certificates/offers.
- A 24-hour advance reservation is required. Reservations are subject to availability at time of booking.
- Certificate must be presented at the Alamo counter on arrival.
- This certificate is redeemable at all Alamo locations in the U.S.A. and Europe\*. Once redeemed, this certificate is void.
- This certificate and the car rental pursuant to it are subject to Alamo's conditions at the time of rental. Minimum age for rental is 21. All renters must have a valid driver's license.
- The maximum value of this certificate which may be applied toward the basic rate of one rental is \$10 OFF in the U.S.A. or 5% OFF in Europe\*. The basic rate does not include taxes and other optional items. Valid on self-drive rentals only. No refund will be given on any unused portion of the certificate. Certificate is not redeemable for cash.
- This certificate is null and void if altered, revised or duplicated in any way. In the event of loss or expiration, certificate will not be replaced.
- Certificate cannot be used in conjunction with an Alamo Express Plus<sup>SM</sup> rental.
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# Colorado Medical Society

## Tentative 1995 Interim Meeting Schedule

### To be held at the CMS offices:

#### FRIDAY, MARCH 10, 1995

11:00 am - 1:00 pm	Finance Committee
1:00 pm - 5:00 pm	Board of Directors

### To be held at the Holiday Inn Southeast (Parker Road @ I-225)

#### FRIDAY, MARCH 10, 1995

6:30 pm - 9:00 pm	Women in Medicine
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#### SATURDAY, MARCH 11, 1995

6:30 am - 5:00 pm	Registration
7:00 am - 10:00 pm	Office open
7:00 am - 8:30 am	Reference Committee Members
7:00 am - 9:00 am	Nominating Committee Open Forum
8:30 am - 9:00 am	Credentials Committee
9:00 am - 9:00 am	House of Delegates - Opening Session
9:30 am - 11:45 am	General Membership Meeting
-	Keynote:
12:00 N - 1:30 pm	Luncheon
2:30 pm - 5:00 pm	Reference Committee on Board of Directors/Constitution, Bylaws and Credentials
4:30 pm - 6:00 pm	Reference Committee on Health Affairs

#### SUNDAY, MARCH 12, 1995

6:30 am - 11:00 am	Registration
7:00 am - 12:00 N	Office open
7:00 am - 8:30 am	Arapahoe caucus
7:00 am - 8:30 am	Aurora-Adams caucus
7:00 am - 8:30 am	Boulder caucus
7:00 am - 8:30 am	Clear Creek Valley caucus
7:00 am - 8:30 am	Denver caucus
7:00 am - 8:30 am	El Paso caucus
7:00 am - 8:30 am	Larimer/Weld caucus
7:00 am - 8:30 am	Pueblo/Western Slope caucus
8:00 am - 8:30 am	Credentials Committee
8:30 am - 12:00 N	House of Delegates - Closing Session

## Call for Nominations

The Nominating Committee will meet during the Interim Session in March to consider nominations for President-Elect, Speaker and Vice-Speaker of the House, two AMA Delegates and two AMA Alternate Delegates and any other offices of the Colorado Medical Society. All persons being considered for elective office must be cleared through this committee. This includes those who will stand for reelection. If you desire to run for office or to nominate someone, please contact Mary Lee Johnston at the Colorado Medical Society (303-779-5455 or 1-800-654-5653) or Dr. Barbara Reed, Chair, CMS Nominating Committee, 2200 E 18th Ave., Denver CO 80206, (303-322-7789). Make this contact as soon as possible so that the committee can properly prepare its report to the House of Delegates.



## Colorado Department of Public Health and Environment

# Colorado's female smokers have more underweight babies

DENVER - Startling statistics, just released by the Colorado Department of Public Health and Environment, clearly show that Colorado women who smoke have a much greater chance of having a low birth weight baby, one that weighs 5 lbs. 8 oz. or less.

Of 54,013 total births in Colorado in 1993, 7,954 of those women said they smoked during pregnancy. Of those, 1,190 delivered low weight babies. That is 1.5 percent, more than double the 7.2 percent of low weight babies born to women who said they did not smoke during pregnancy.

"Colorado women have a problem with low weight babies, and smoking is not helping," according to Patricia A. Nolan, M.D., MPH, executive director of the department. "These statistics clearly show a correlation between 'lighting up' and having an underweight baby."

"Women can no longer hide from the fact that if they smoke during pregnancy, it will negatively affect the baby," according to Jeremiah Bartley, M.D. "Low weight babies often have many health problems such as respiratory problems, jaundice, possible association with Sudden Infant Death Syndrome, and neurologic abnormalities. This can be traumatic for the family, both in the extra time the baby may need to spend in the hospital, and the cost to treat the problems. Children who are underweight at birth often have severe health problems for the rest of their lives."

According to results from a

1991-93 statewide survey, more than 26 percent of smokers said they had no health insurance, compared to 12 percent of the nonsmokers. The Behavioral Risk Factor Survey was done using extensive phone surveys. This indicates a large amount of health care costs, including those for low weight babies, that must be covered by public health care programs.

Statistics also show that the number of cigarettes smoked per day is correlated with the percent of low weight babies. The information was given voluntarily by women on birth certificate forms collected by the Health Statistics and Vital Records Division in the department. The department has been collecting the data related to pregnant women smoking since 1989.

In 1993:

- 3,272 women said they *smoked less than 10 cigarettes per day*. 13.7 percent had low weight babies.
- 2,918 women *smoked 10-19 cigarettes per day*, 15 percent had

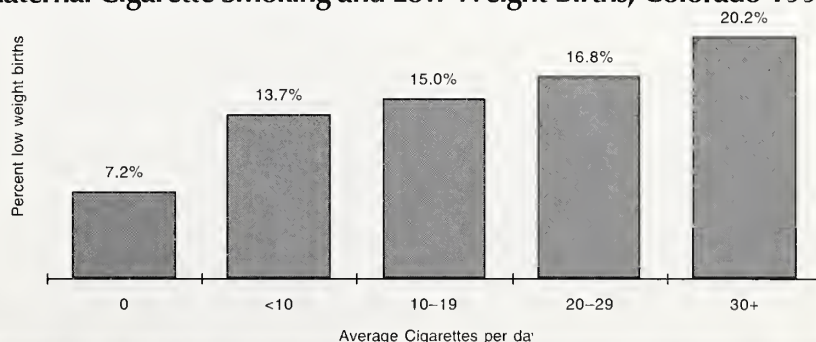
low weight babies.

- 1,551 *smoked 20-29 cigarettes per day*, 16.8 percent had low weight babies.
- 213 *smoked 30 plus cigarettes per day*, 20 percent had low weight babies.

The percentage of low weight babies directly increased with the number of cigarettes the mother smoked. "This is one more example to be added to the long list of harmful effects of tobacco use," according to Dr. Nolan with the department. "I encourage women to stomp out their cigarettes, especially during pregnancy, if not giving them up forever."

Pregnant smokers who have received prenatal services through the Colorado Department of Public Health and Environment's Prenatal program in recent years have successfully demonstrated the value of stopping smoking. Fully 31 percent of these women were able to quit during pregnancy and their low birth weight fell to 7.5 percent which is below the state average.

**Maternal Cigarette Smoking and Low Weight Births, Colorado 1993**







### How much is your Social Security Protection worth?

Answers:

1. C. If you had average earnings most of your working life and retire at the normal retirement age (currently age 65), your benefits would replace about 42 percent of your pre-retirement earnings. If you had low earnings, the replacement rate would be about 57 percent. At the maximum earnings taxable by Social Security, the replacement rate is about 24 percent.

2. B.

3. A. You would have paid \$62,083 in retirement and survivors insurance taxes (in today's dollars) and would receive a benefit of about \$856 a month (also in today's dollars). It would take you 10 years to get your money back in retirement benefits. These results can vary significantly depending on your earnings level and age of retirement.

4. B.

5. C. Social Security expenses come to less than 1 percent of program income.

6. A. Private insurance companies do not offer a package similar to Social Security so any real comparison is difficult.

7. A. Social Security taxes can be used only to pay benefits and pay the administrative costs of the program. The law provides that funds not used for this purpose are invested in government bonds.

8. C. Social Security provides a partial replacement of lost earnings following the retirement, disability, or death of a family breadwinner.

9. B. Life insurance protection (survivors insurance) alone under Social Security in 1993 was worth \$12.1 trillion, 1.3 trillion more than the \$10.8 trillion for all private life insurance in force.

Far too many people underestimate the value of their Social Security protection. This is particularly true if they are not now one of the six persons in the population collecting Social Security retirement, disability, or survivors benefits.

Nevertheless, part of the value of Social Security is knowing exactly what is there and how it will serve your needs.

The following questions are designed to help you assess the value of your Social Security protection.

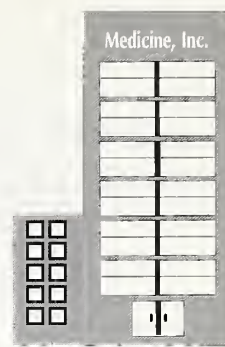
1. If you have average earnings most of your working life, your Social Security retirement benefit will replace how much of your pre retirement earnings at age 65?
  - A. 90 percent
  - B. 20 percent
  - C. 42 percent
2. If you have paid the maximum Social Security and Medicare taxes all your life and retired this year, the most you would have paid is about:
  - A. \$27,000 for Social Security and \$15,000 for Medicare
  - B. \$45,000 for Social Security and \$13,000 for Medicare
  - C. \$107,867 for Social Security and \$51,000 for Medicare
3. If you were born in 1977, retire at the normal retirement age (age 67 by that time) and earn average wages, how long do you think it would take you to get the money back you paid for retirement and survivors benefits, including interest.
  - A. About 10 years
  - B. About 5 years
  - C. About 6 months
4. What do you think the chances are of becoming disabled before

reaching retirement?

- A. As a man, one out of 50; as a woman one out of 60
  - B. As a man, one out of 3; as a woman one out of 4
  - C. As a man, one out of 20; as a woman one out of 25
5. How much do you think it costs to administer the Social Security program as a percentage of the taxes Social Security takes in?
    - A. About 20 percent
    - B. About 10 percent
    - C. Less than one percent
  6. How do you think Social Security compares with private insurance as an investment?
    - A. No insurance company will give such a package.
    - B. Insurance is a better investment.
    - C. Private insurance covers more.
  7. Social Security taxes are used to:
    - A. Pay benefits and administrative costs of the program.
    - B. Pay for any government expenses.
    - C. Pay for education, housing, welfare.
  8. The role that Social Security plays in providing financial security for society as a whole is best illustrated by the following statement:
    - A. One out of six Americans receive a Social Security benefit.
    - B. Social Security keeps over 35 percent of Americans over 65 above the poverty line.
    - C. Both of the above.
  9. Total life insurance protection provided by private life insurance companies in 1993 was \$10.8 trillion. Under Social Security life insurance protection totaled:
    - A. Zero
    - B. \$12 trillion
    - C. \$5 trillion

# Corporate Practice of Medicine

## No Longer "When?" but "How?"



The hackneyed expression, "Times are changing," applies to the practice of medicine now more than ever. The arrangements under which we practice medicine today are much different than they were even a decade ago. There are more professional corporations, less solo practice, more contractual relationships between physicians and other entities. And, yes, there is even the direct employment of physicians by non-physicians—the corporate practice of medicine! Colorado still remains one of the handful of states in the U.S. with some prohibition against the corporate practice of medicine, but recent legislation has allowed the direct employment of physicians by hospitals in Colorado counties with a population of 100,000 or less. As a result of this legislation, physicians may already choose to be employed by hospitals, and as a result of the way health care delivery is going generally, they may in the near future, also wish to be employed by other entities that provide medical care. However, the physician's right and duty to give patients the appropriate medical care must be preserved whether that physician practices independently, in a direct employment situation, or through a contractual arrangement.

The recently enacted legislative changes regarding the corporate practice of medicine and the changes occurring in the health care delivery system prompted the Colorado Medical Society House of Delegates at the 1994 Annual Meeting to adopt a policy on the corporate practice of medicine about which all CMS members should be

aware. The policy states that the Colorado Medical Society supports adherence to the following ethical and legal guidelines which apply to any type of practice arrangement:

1. Physicians must use their best efforts and skills in the care of patients and must be ever wary of those forces in society that can erode ethical medical practice.
2. The welfare of patients lies above the financial interest of the physician and of any hiring or contracting entity.
3. Clinical decision making must remain in the hands of the physician. No entity that employs or contracts with physicians to provide medical care should limit or otherwise exercise control over the physician's independent professional judgment concerning the practice of medicine or diagnosis or treatment in such a manner as to compromise patient care.
4. Physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward or the avoidance of financial penalties. Any entity which employs physicians or contracts with them must assure adequate disclosure to patients and other interested parties of any financial inducements that may limit the diagnostic and therapeutic alternatives offered to patients or that may limit patients' overall access to care.
5. No entity that employs or contracts with physicians to provide medical care may offer

### *Seven Guiding Principles from the CMS House of Delegates.*



## **"...never compromising our principles of quality patient care and our ethical obligations as advocates for our patients."**

these physicians any percentage of fees charged to patients for referred services provided by this entity or any other financial incentive to artificially increase services provided to patients.

6. The bylaws of any hospital which employs or contracts with community based physicians shall not discriminate with regard to credentials or staff privileges on the basis of whether a physician is an employee of, or a contracting physician with, the hospital.
7. Hospitals which employ or contract with physicians may not limit hospital-based referrals exclusively to those physicians whom they employ or with whom they contract if such a limitation on referrals compromises patient care.

In all arenas, Colorado Medical Society must advocate first for the welfare of our patients, and then for the welfare of our profession. Since physicians took the Oath of Hippocrates, we have assumed the task of safeguarding the doctor-patient relationship and the ethical behavior of our profession, and overseeing those outside influences which would put profit motives before the welfare of our patients. Although CMS has not come out endorsing the corporate practice of medicine, as the waves of change roll in, we will gain more for our patients and profession by assuring that our 7 principles of Corporate Practice be included in any relationship between a physician and a proprietary interest, than by continuing to categorically oppose Corporate

Practice.

Our House of Delegates has instructed the Health Affairs Council to implement enforcement of these principles. This can be accomplished, short of legislating them as a stand-alone bill, through a multifaceted approach. First, we must educate our members on our Corporate Practice Policy. For those of you who are involved in direct employment relationships with proprietary interests, such as hospitals and insurance companies, or in cooperative ventures such as physician-hospital organizations, distribute the policy to both your employer and other affected physicians. If you perceive a breach in the policy, discuss the issue with your group and employer. CMS, at the same time, will activate the CMS Council on Ethical and Judicial Affairs (CEJA), to become a resource for all physicians who need assistance in dealing with potential breaches in the policy. As a CMS member, if such a situation arises, please communicate your concerns to CEJA. They will consider such issues under their expanded charge. The AMA Council on Ethical and Judicial Affairs has become a major resource to that organization in dealing with such ethical issues. As our health care delivery system moves forward with integration, such challenges in dealing with ethical issues will become more common. We will look towards the CMS CEJA, a body composed of wiser and often older physicians, set apart from the House of Delegates and the Board of Directors, for such help.

CMS will also work with organizations which may come forward

attempting to change Colorado law to permit corporate practice in cities with populations greater than 100,000. We will advocate for the inclusion of our Corporate Practice Policy in any such proposed legislation. We will also be vocal to appropriate governmental regulatory agencies regarding our policy.

CMS has long fought the concept of corporate practice of medicine in Colorado. In past years, such a position served our patients and profession well. Last year, our state legislature changed the law to permit corporate practice in cities with populations less than 100,000. Colorado is only one of 6 states with any prohibitions on corporate practice at this time. As we move forward in the changing health care environment, it will be important to be flexible in certain positions while at the same time never compromising our principles of quality patient care and our ethical obligations as advocates for our patients. It is with this intent that the CMS House of Delegates passed our new Corporate Practice Policy. We believe that implementation of the principles of the CMS Corporate Practice Policy will serve all parties well.

# Local Physician Input Sought

## In Planning Community School-Based Health Centers

At the September, 1994 Annual Meeting, the CMS House of Delegates adopted the following resolution on School-Based Health Centers:

RESOLVED, that the Colorado Medical Society recognizes school-based health centers as an effective approach to reaching previously inaccessible children and adolescents with medical and mental health care needs; and be it further

RESOLVED, that CMS encourage physicians to participate in the community planning process of school-based health centers; and be it further

RESOLVED, that CMS supports the efforts of the School-Based Health Center Initiative to obtain funding from the Robert Wood Johnson Foundation, or other appropriate funding sources, to allow existing programs to expand and/or new programs to begin providing services; and be it further

RESOLVED, that school-based health centers should, when possible, refer and coordinate care with community practitioners.

Following the passage of this resolution, the State Coordinating Council of the School-Based Health Center Initiative passed a resolution that calls for communities which are planning new school-based health centers to "actively seek the involvement of local physicians and physician organizations." As one means of achieving this goal, the Coordinating Council provided to *Colorado Medicine* a list of contact people in the communities that have received school-based health center planning grant money from the Robert Wood Johnson Foundation.

### Background

Earlier this year, the Colorado Department of Health received a planning grant from the Robert Wood Johnson Foundation to develop a state and local partnership for establishing new school-based health centers in the state. The planning grant extends through March of 1995 and enables successful community applicants to receive technical assistance and training in establishing school-based health centers. The State Coordinating Council, a broad-based group including state organizations, and local providers of health and education services, was convened to steer the initiative.

The Council subsequently selected eight communities to receive assistance in planning school-based health centers. In 1995, three or four of the eight communities will be chosen to receive implementation grants. (For the purposes of the grant, communities were defined as school districts. Small districts were allowed apply in combination with other small districts.)

The eight communities which received planning assistance are listed below. **Physicians who are interested in participating in the school-based health center planning process in these communities are encouraged to call the listed contact person.**

Area	School District	Proposed School(s)/ School Size(s)	Contact Person
Brighton	Adams County School District 27 J - Brighton	Overland Trail MS - 533 Vikan MS - 460	Cristine Clarke 892-0004
Denver	Denver Public Schools	JFK HS - 1340 North HS - 1801 Kepner MS - 972 Rishel MS - 783	Paul Melinkovich, MD 436-7433
Fort Collins	Poudre School District R-1	Centennial HS - 153 Lincoln JH - 631 Leshier JH - 611 Eyestone ES - 624	Rebecca Jansen 490-3664
Jefferson County	Jefferson County Schools R-1	Jeffco Open School PK-12 - 654 Elber ES - 515 Stein ES - 677 Arvada MS - 580	Betty Fitzpatrick 273-6680
Pueblo County	Pueblo School Dist. # 50	Corwin MS - 672 Risley MS - 492 Freed MS - 702	Bev Samek 719-549-7159
Roaring Fork (Carbondale, Basalt, Glenwood)	Roaring Fork School District RE-1	Basalt Schools K-12 - 1200	Abby Lochhead 945-6766
San Luis Valley	Alamosa & Center	Alamosa HS - 200 MS/HS-298	Antonio Gurule 719-589-5111
Wiley, Granada, Holly	Wiley, Granada, & Holly School Dists.	K- 12 - 330 K - 12 - 290 K - 12 - 350	Donna McDonnell 719-336-2053

Legend: ES = Elementary School MS = Middle School HS = High School





# Are your patients managing your finances?

## ...and are they qualified?

by Virginia A. Borgeson and Pat Smith, I.C. System, Inc.



I.C. SYSTEM

If you didn't write your own policies for managing your accounts receivable, then who did? Are the people who owe you money deciding when and if you will be paid?

Successful managers understand the importance of a comprehensive accounts receivable system. MONEY is the name of the game. Those who have it and use it wisely are successful; those who don't are subject to rapid failure. Take control... here are some tips for managing this critical function.

First, begin with the establishment of a definite policy regarding the extension of credit. The individual characteristics of your business and competitive environment will affect your policy. You may consider everything from no extension of credit, to achieve a zero accounts receivable balance, to a liberal granting of terms to selected classes of clients. In particular, your policy should assign the responsibility for managing accounts receivable to only one person, and this person should report and be accountable to senior management.

An example of a simple credit policy might be:

- All credit applicants must complete a credit application.
- All credit applications must be approved by senior management.
- All approved credit applicants

must be given an explanation of payment schedules and dollar amount limits.

- Credit will not be extended to any patient whose account is 60 days past due.

Different accounting transactions present unique accounts receivable problems and some require more careful planning and control than others. For instance, a doctor who receives payments from insurance companies may have to institute one policy to handle insurance payments and timing, and another for directly billed patients. A supplier may have a policy for his small retail customers, and a separate policy for large wholesale buyers. The point is, different types of transactions require different handling and timing to maximize accounts receivable results.

Even with a credit policy in place, you may not be the manager of your finances. Past due accounts are the nemesis of every business. Yet, if you don't address this issue, you're letting your least profitable customers establish your policy for amounts which might equal or exceed your whole bottom line performance.

Every business which extends credit needs to establish, at the same time, a firm policy for handling past due accounts. Collection policies are as critical as credit policies.



A collection policy can be as simple as your credit policy. For instance:

- The Accounts Receivable Manager is responsible for all collection activity.
- An account becomes eligible for collection activity when it becomes 60 days past due.
- An account receiving collection activity will be pursued for 45 days.
- After 45 days, all unpaid accounts will be turned over to an outside professional collection agency.

You will make collection of past due accounts more consistent and easier by having a written policy which tells whose job it is, when you're going to start, when you're going to stop, and what happens after you stop.

Bottom line... after 180 days, you have only a one-in-three chance of receiving payment on a debt. And you're actually losing money in more ways than one.

I.C. System, the largest privately-owned debt management company in the country, is endorsed by the Colorado Medical Society as an effective and ethical debt collection service. Since 1980, I.C. System has collected over \$4,754,000 for CMS members.

If you need to take a new look at who's managing your finances and could use some help, call the CMS office at 779-5455. Only you are qualified to manage your finances.

## Unpaid Collectibles Cost You Time and Money...

Current worth



Three months      Six months      One year      Two years      Three years





# IME Rules:

## Interference or Insurance?

by Michael P. Thompson

*Some history may help physicians decide how to deal with attorneys' requests in connection with IME's.*

In September, 1994, the Workers' Compensation Advisory Committee (WCAC) of the Colorado Medical Society proposed two resolutions dealing with hassles involved in performing Independent Medical Examinations (IMEs). IMEs are often performed in connection with Workers' Compensation cases as an additional factor in determining whether and at what level disability exists after an injury.

The WCAC noted that some attorneys request information such as income levels, method of billing, amounts collected, percentage of physician income derived from IME fees and the like. The committee felt that this information was irrelevant to the quality of the IME, which is really what is at issue. In addition, the WCAC cited other factors which they would consider inappropriate interference with the IME. These included the use of tape recorders or non-physician witnesses during the examination, refusal to release medical records, refusal to submit to a complete medical history if requested by the examining physician and any stipulations limiting the ability of the IME physician to render a complete and independent opinion.

After some comment by CMS legal counsel Robert R. Montgomery, the House of Delegates referred the two resolutions involved back to the WCAC for further study. Mr. Montgomery noted in a follow-up letter to the CMS that financial records might be considered relevant to the case if, for instance, the physician made 90% of his or her income examining injured workers for employers. That

would present a potential conflict of interest which could influence the finding of the IME.

Mr. Montgomery also advised that the resolutions might be more effective if they sought cooperation with administrative law judges in not granting requests for unrelated records, rather than being phrased in an adversarial manner. He also noted that defense attorneys who specialize in workers' compensation cases might be a good ally, as they "have a direct stake in trying to protect the physicians who agree to do IMEs".

Mr. Montgomery also pointed out that the resolution stated that the onerous requests are sometimes used by attorneys to discourage physicians from participating in IMEs. If the physician unilaterally rebels against what he or she perceives as unreasonable demands and therefore refuses to carry out the examination, then this "harassing" tactic has been successful.

Karen B. Best, Esq., an Associate with the law firm of Montgomery Little and McGrew, joined Mr. Montgomery in expressing concerns over the wording in these two resolutions. A letter from these two attorneys said the fact that "there are some lawyers who use these requests as a device to discourage a physician from conducting an IME is right on target, and the practice should be condemned." However, they also noted that the resolutions said the financial information was "irrelevant". If the court orders disclosure of the information, it is considered "relevant" whether or not the physician agrees. According to the

## IMEs, ALJs and the WCAC: What's a Doctor to Do?

attorneys, "Having the Society and its members make judgments about the relevance of information could also arouse resentment on the part of Judges who consider discovery matters their domain, and not the province of physicians, or lawyers or anyone else."

The principle involved is to seek a mode of cooperation with the judge and the defense attorney which can eliminate interference proposed by a plaintiff's attorney. If a physician who has been asked to do an IME believes that irrelevant and interfering conditions are being attached to the examination, he or she should agree to do the examination, but not agree to the conditions, according to articles in *Colorado Medicine* by attorney Karen Best. That puts the onus on the attorney demanding the conditions to prove that they are necessary and relevant. The physician then has opportunity to convince the judge that they are not.

The two attorneys noted existing federal court rules regarding disclosure of information about expert witnesses which may be relevant to the issue of an IME. In such cases, every expert is required to report every opinion which will be tendered, submit all exhibits or summaries, including overheads and slides, reveal whatever compensation will be received, and provide a list of all publications for the past ten years and all cases in which the expert has testified in the past four years. The expert must also disclose all information "considered" in forming an opinion, even if it was not relied upon in forming the opinion. In

Colorado courts, similar rules go into effect 1/1/95. (Colorado Rule of Civil Procedure, Rule 26(a)(2)(B). Call CMS if you desire a copy of this rule.)

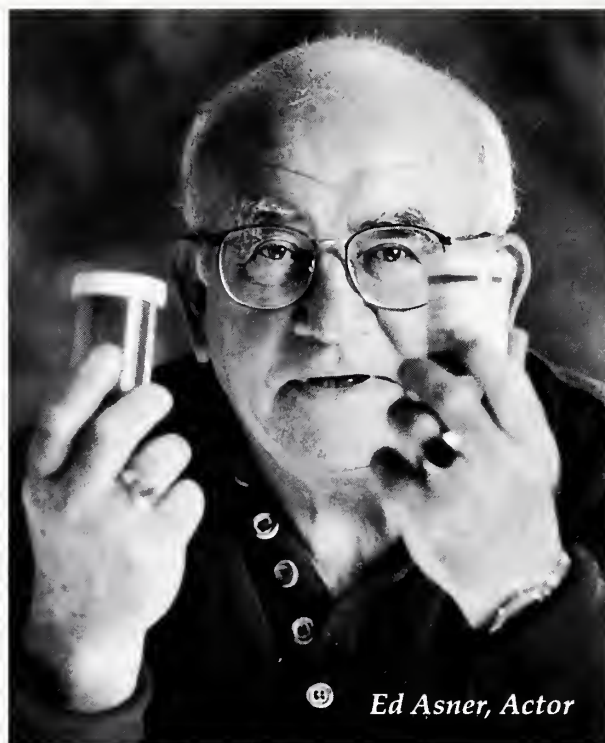
Neither of these rules specifically require disclosure of physician's financial records, as was the grievance addressed by Resolution 57P-AM 94, nor do they apply to Administrative Law Judges hearing Workers' Compensation cases. However, they both represent an expansion in the information requested by courts of those who provide expert testimony and information and will likely have an influence on what the ALJ will require of physicians providing IMEs.

Mr. Montgomery recommended a revised wording on the Resolution which would put CMS on record as saying that requests for unrelated information are inappropriate and urges cooperation with the Colorado Bar Association and the Plaintiff's Bar and others to condemn inappropriate tactics resolve the issue amicably. The WCAC will be take this under consideration for possible introduction at the Interim Meeting in March.

*"The principle involved is to seek a mode of cooperation with the judge and the defense attorney which can eliminate interference"*



# Attention: Physicians



Ed Asner, Actor

## Have your patients' medicines had a check-up?

**M**any of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

The next time you prescribe a medicine, ask your patients:

*"What other prescription and nonprescription medicines are you taking?"*

**YES!** Please send me free information to use when talking with my patients about their multiple medicine use.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

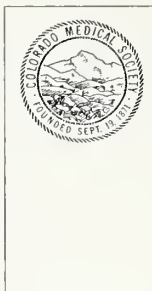
State \_\_\_\_\_

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Mail to:

✉ NCPIE  
✉ 666 Eleventh Street, NW  
Suite 810  
Washington, DC 20001

OR FAX:  
(202)638-0773



## National major managed care firm takes over Take Care/Comprecare

Colorado's Division of Insurance has ratified the merger of three managed care plans creating the state's largest health plan, to be called FHP Health Care.

The resulting company, FHP of Colorado, Inc., provides health coverage for more than 325,000 Coloradans, including those covered by TakeCare and Comprecare plans.

Effective January 1, 1995, FHP of Colorado will offer its portfolio of health care products under the umbrella name "FHP Health Care". Completion of the plans' merger follows FHP International Corp.'s acquisition of TakeCare in June; TakeCare had acquired Comprecare in September, 1993.

Stephen T. O'Dell, president of FHP of Colorado, hastened to point out that "We're integrating our plans and changing our name, but we remain centered on offering patients a broad choice of doctors, quality care — including our emphasis on preventive services — and the value we believe Coloradans want from their health care plan".

The FHP of Colorado, TakeCare and Comprecare benefits plans continue under their current names until Jan. 1, 1995, when all of the company's health plans will carry the FHP name.

FHP has relationships with

nearly half the doctors in the state, more than 20 hospitals and hundreds of pharmacies. FHP Health Care is principally in Front Range communities, from Pueblo to Fort Collins..

O'Dell added there will be no change in the day-to-day operations, except for the new name on the ID cards. He said FHP Health Care will remain a locally-managed company. FHP International, the parent company, is the fifth largest managed care company in the country, which delivers health care to more than 1.7 million persons in Colorado, California, Arizona, Utah, New Mexico, Nevada, Illinois, Ohio, Texas, and the territory of Guam. The company is based in Fountain Valley, Calif

## Texas Medical Association warns members of GE Medical Plan's "unique benefit protection offer for patients".

*(Excerpts from TMA Chart, Vol. 8, No. 7)*

It has come to the attention of the Texas Medical Association (TMA) that the GE Medical Benefits Plan offers unique employee protection for paying medical charges in excess of the reasonable and customary amount.

GE employees are advised that "if you qualify for this protection you are not responsible to pay charges above the reasonable and customary

amount. You do not qualify if you have agreed with your doctor, either verbally or in writing, to pay a specific amount." TMA says that in addition, GE employees are advised that if they have not entered an agreement with the physician they should notify the GE Medical Plan if they are billed for the "Excluded Amount" shown on the EOB. GE Medical Benefits will then work on behalf of the patient to resolve the matter with the physician, **including defending the patient in court in the event of legal action, at no cost to the patient.**

Texas Medical Association admonishes its members that "to avoid confusion regarding payment for services rendered, GE employees should be advised at the time of service that your office has not signed an agreement with GE Medical Benefits and that the patient is responsible for the entire balance after insurance".





### Colorado Disease Bulletin Available to Physicians

The *Colorado Disease Bulletin* is published monthly by the Colorado Department of Public Health and Environment and is available at no charge to physicians practicing in the state. The four page *Bulletin* provides information and recommendations on communicable and non communicable diseases of state and national importance. To subscribe call Koral O'Brien at (303)692-2627 or write to: Colorado Department of Public Health and Environment, Attn: Koral O'Brien, DCEED-DSI-A3, 4300 Cherry Creek South Drive, Denver, Colorado 80222-1530.

### Proposed Changes in Reportable Disease Regulations

At the January 18, 1995 Board of Health meeting, public testimony will be taken on proposed amendments to regulations pertaining to reporting of epidemic and communicable diseases and causes of morbidity and mortality. The following changes are proposed:

Conditions proposed to be added to the list of diseases reportable by physicians or other health care providers within 7 days are:

- 1) the following PPD skin test results if they occur in a health care worker, correctional facility worker, or detention facility worker: recent conversion in a PPD skin test (defined as within

a 2 year period > 10 MM change in duration is < 35 years or > 15 MM change in duration if > 35 years of age) or positive PPD (defined as > 5 MM in duration) if a close contact of a newly diagnosed infectious tuberculosis case.

- 2) Cryptosporidiosis
- 3) Delete syphilis from the list of diseases that must be reported within 24 hours and add to the list that requires reporting within 7 days.

From the list of diseases reportable within 7 days the following change in the manner of reporting has been proposed:

- For *Campylobacter* Infections, remove the requirement that the patient's name, age, sex, address and name and address of responsible physician be reported and instead report only the number of cases.

Additionally proposed is that fatal and nonfatal firearm related injuries be reported within 180 days. Such reporting may be coordinated through a computerized data system that the Colorado Department of Public Health and Environment shall develop.

The Board of Health meets at the Colorado Department of Health, Sabin/Cleere Conference Room, First Floor, 4300 Cherry Creek Drive South, Denver, CO. The exact time of the hearing will be available on or after January 6, 1995. To obtain the exact time or other information regarding the meeting call Linda Shearman at 303-692-2025.

### Copic Medical Foundation Awarded Grant

The Robert Wood Johnson Foundation has awarded to Copic Medical Foundation a grant of \$823,169, in support of a feasibility study and demonstration of an alternative to the current litigation-driven medical malpractice system for compensation of patients injured during medical procedures. Additional funds have been contributed by Copic Medical Foundation itself, and Copic Insurance Company has dedicated in-kind support to the study and demonstration.

"I hope the study will identify better ways to define disabling injuries and provide compensation for those injured in the system," noted K. Mason Howard, M.D., President of Copic Medical Foundation. Dr. Howard will be directing the eighteen month study.

According to Howard, the study will apply the investigation methodology of a similar study conducted in New York, published in 1990. He anticipates that the Colorado study will initially validate the findings in New York, including the indication that of all patients identified as being injured during the course of hospital care only 15% received any compensation for those injuries through the tort system. Furthermore, nearly two-thirds of the money expended went to transaction costs of the system, rather than to those who sustained injuries.

Data will be gathered and analyzed from 10,000 medical



records at fifteen Colorado hospitals, as well as reviewing information from Copic claim files and court records of malpractice complaints filed. Copic has also approached the Board of Medical Examiners (BME), requesting access to their data on medical injury and settled claims, which are required to be reported.

Following the gathering and analyzing of Colorado data, Howard hopes to compile recommendations which would include creation of an administrative system for compensation of patient injury, enhanced provider discipline and mandated risk management in the health care delivery sector. He envisions a system in which patient claims would be processed by a quasi-governmental agency, outside the current system of torts and courts. Compensation would address such items as wage loss, out-of-pocket expenses, survivor benefits, and noneconomic losses within existing limits defined in Colorado statutes.

The ultimate intent of this project is to develop an entirely new system with several desirable characteristics:

- Speedy, non-fault-based compensation awards to injured patients.
- Enhanced provider discipline, primarily through improvement in reporting and case-finding mechanisms.
- Evolution of focused,, Colorado-specific risk management activities based upon injury data collected through patient complaints and provider reports.

This grant was awarded under Robert Wood Johnson Foundation's program titled *Improving Malprac-*

*tice Prevention and Compensation Systems (IMPACS).* The Foundation makes grants toward four goals: assuring access to basic health services; improving the way services are organized and provided to people with chronic health conditions; promoting health and preventing disease by reducing harm from substance abuse; and seeking opportunities to help the nation address the problem of escalating medical costs.

The Copic Medical Foundation is an nonprofit corporation organized exclusively for the benefit of and to provide support for charitable, educational, civic and scientific purposes related to medicine, medical education, medical research, and other medical charitable purposes.

## REACH OUT grant

The Robert Wood Johnson Foundation has invited county, state

and specialty medical societies to submit proposals for grants totaling \$14 million, in the second round of its REACH OUT program.

REACH OUT is the Foundation's major national effort to mobilize private physicians to improve access to care for medically underserved Americans. RWJ awarded \$2.2 million to 22 private physicians' groups, including 13 medical societies.

**The Colorado Chapter of the American Academy of Pediatrics**, in Englewood, Colorado has been selected as a recipient of this award. The grants of nearly \$100,000 each are for one-year planning programs. Awardees are eligible to receive three-year implementation grants averaging \$200,000.

For information on grant proposals contact the REACH OUT National Program Office at (401) 453-5120 at Brown University.



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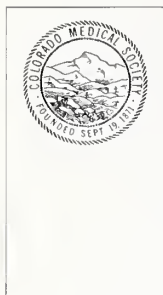
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761-7600

### LAKEWOOD

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238-1366

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## NEW MEMBERS

*Here are the names and addresses of those who have been elected members of the Colorado Medical Society since our last report. Information is provided by the component societies.*

### ARAPAHOE MEDICAL SOCIETY

Glenn M Bolton, MD  
16173 E Crestline Pl  
Aurora, CO 80015  
Elected 06/21/94

Julie C Deckerman, MD  
8200 E Bellview Ave #204  
Englewood, CO 80111  
Elected 07/01/94

Stephen V Eppler, MD  
701 E Hampden Ave #410  
Englewood, CO 80110  
Elected 07/01/94

Robert E Henson II, MD  
499 E Hampden Ave Ste 450  
Englewood, CO 80110  
Elected 07/01/94

Timothy L Vollmer, MD  
701 E Hampden Ave #420  
Englewood, CO 80110  
Elected 02/15/94

Josephine M A Williams, MD  
499 E Hampden Ave #230  
Englewood, CO 80110  
Elected 04/19/94

### AURORA-ADAMS COUNTY MEDICAL SOCIETY

Charles L Boursier, MD  
14231 E 4th Ave #101  
Aurora, CO 80011  
Elected 05/23/94

William J Bowen, MD  
14231 E 4th Ave #101  
Aurora, CO 80011  
Elected 05/23/94

Samuel Y Chan, MD  
830 Potomac Cir #290  
Aurora, CO 80011  
Elected 08/23/94

Frederick W Eframo, DO  
897 S Havana St  
Aurora, CO 80012  
Elected 10/24/94

Michel L Gevaert, MD  
830 Potomac Cir #290  
Aurora, CO 80011  
Elected 08/23/94

Kevin J Heinze, MD  
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Aurora, CO 80012  
Elected 09/23/94

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Aurora, CO 80011  
Elected 05/23/94

Randy S Jacobs, MD  
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Aurora, CO 80011  
Elected 05/23/94

Richard T Loeffler, MD  
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Aurora, CO 80011  
Elected 05/23/94

Suman S Morarka, MD  
15101 E Iliff Ave #200  
Aurora, CO 80014  
Elected 07/01/94

Robert J Nordness, MD  
14231 E 4th Ave #101  
Aurora, CO 80011  
Elected 05/23/94

Neal P O'Connor, MD  
14231 E 4th Ave #101  
Aurora, CO 80011  
Elected 05/23/94

F Mark Paz, MD  
10620 Raspberry Mtn  
Littleton, CO 80127  
Elected 09/23/94

Michael G Ratliff, DO  
450 S Lafayette St  
Denver, CO 80209  
Elected 08/23/94

Joyce S Rosenfeld, MD  
14231 E 4th Ave #101  
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Elected 05/23/94

Eric J Rothgeb, MD  
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Aurora, CO 80011  
Elected 05/23/94

Deborah H Sainer, MD  
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Elected 07/15/94

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Elected 07/01/94

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Elected 08/23/94

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James P Sutton, MD  
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Aurora, CO 80011  
Elected 05/23/94

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Elected 05/23/94

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5085 S Shenandoah Way  
Aurora, CO 80015  
Elected 10/01/94

### BOULDER COUNTY MEDICAL SOCIETY

Martha A Cabeen, MD  
1130 Alpine  
Boulder, CO 80302  
Elected 10/27/94

Mary E Faini, MD  
1309 Sunset St  
Longmont, CO 80501  
Elected 08/25/94

Jonathan E Jensen, MD  
1155 Alpine Ave # 300  
Boulder, CO 80304  
Elected 10/27/94

Diane L Kallgren, MD  
3575 Broadway  
Boulder, CO 80304  
Elected 07/07/94

Ann C Martin, MD  
1332 Linden St  
Longmont, CO 80501  
Elected 08/25/94

Alfred Purdon Jr, MD  
1155 Alpine # 230  
Boulder, CO 80304  
Elected 08/25/94

Robert C Rountree, MD  
4150 Darley Ave # 6  
Boulder, CO 80303  
Elected 10/27/94

Ronald A Sarno, MD  
15140 King Court  
Broomfield, CO 80020  
Elected 07/07/94

Samuel E Smith, MD  
1331 Linden St  
Longmont, CO 80501  
Elected 08/25/94

Kristina R Tedeschi, MD  
1925 W Mountain View Ave  
Longmont, CO 80501  
Elected 10/27/94

Warren H Valencia, MD  
1350 Stuart St  
Longmont, CO 80501  
Elected 08/25/94

### **CHAFFEE COUNTY MEDICAL SOCIETY**

Richard D Gage, MD  
543 E 1st  
Salida, CO 81201  
Elected 04/15/94

### **CLEAR CREEK VALLEY MEDICAL SOCIETY**

Aimee S Barteck, MD  
8805 W 14th Ave #110  
Lakewood, CO 80215  
Elected 08/16/94

Claude A Brachfeld, MD  
4200 W Conejos Pl #220  
Denver, CO 80204  
Elected 06/07/94

Jeffrey S Cross, MD  
4200 W Conejos Pl # 214  
Denver, CO 80204  
Elected 11/08/94

Anthony J Deckert, DO  
3479 W 114th Cir # B  
Westminster, CO 80030  
Elected 08/16/94

Adam Deutchman, MD  
4200 W Conejos Pl # 214  
Denver, CO 80204  
Elected 10/13/94

Robert R Gibson, MD  
8515 Pearl St # 300  
Thornton, CO 80229  
Elected 10/13/94

Kenneth R Lamkin, MD  
205 S Garrison St  
Lakewood, CO 80226  
Elected 08/17/94

Kelli Lewis, MD  
8300 W 38th Ave  
Wheat Ridge, CO 80033  
Elected 08/18/94

Lester Lockspeiser, MD  
4200 W Conejos Pl #220  
Denver, CO 80204  
Elected 06/07/94

Michael N Mills, MD  
27942 Golden Gate Cyn Rd  
Golden, CO 80403  
Elected 10/05/94

Marc J Morse, MD  
5400 Ward Rd  
Bldg-1 # 100  
Arvada, CO 80002  
Elected 09/08/94

James H Pulju, MD  
8550 W 38th Ave # 300  
Wheat Ridge, CO 80033  
Elected 08/16/94

Melissa Ray, MD  
9141 Grant St # B-30  
Thornton, CO 80229  
Elected 08/18/94

Douglas J Redosh, MD  
8774 Yates Dr # 300  
Westminster, CO 80030  
Elected 08/26/94

Jeffrey S Rumblyrt, MD  
8805 W 14th Ave #202  
Lakewood, CO 80215  
Elected 06/07/94

Francis J Rust, MD  
205 S Garrison  
Lakewood, CO 80226  
Elected 08/25/94

Cindy A Smith, MD  
198 Union Blvd # 104  
Lakewood, CO 80228  
Elected 08/16/94

David E Strom, MD  
3555 Luthern Pkwy # 380  
Wheat Ridge, CO 80033  
Elected 11/10/94

Allan M Sulzer, MD  
4200 W Conejos Pl #220  
Denver, CO 80204  
Elected 06/07/94

Ruth A Vanderkooi, MD  
8753 Yates Dr #110  
Westminster, CO 80030  
Elected 09/08/94

Donald M Vickery, MD  
1726 Cole Blvd  
Bldg 22 #200  
Golden, CO 80401  
Elected 06/28/94

### **CMS DIRECT MEMBERS**

Mushtaq Ahmad, MBBS  
8707 Westwind Ln  
Littleton, CO 80126  
Elected 09/19/94

Tyrone E Arce, MD  
679 S Reed Ct  
Bldg 1 # 403  
Denver, CO 80226  
Elected 09/19/94

Stephen J Augustine, DO  
1818 S Quebec Way  
Bldg 2 # 3  
Denver, CO 80231  
Elected 09/19/94

Harold A Barnard, DO  
14261 E Tufts Pl # 208  
Aurora, CO 80015  
Elected 09/19/94

Dhiraj Bedi, DO  
4949 Garden Trail  
Colorado Springs, CO 80918  
Elected 09/19/94

Dustin Bernard-Maughan, DO  
1329 16th Ave  
Greeley, CO 80631  
Elected 09/19/94

Daniel J Bredar, MD  
1291 S Columbine St  
Denver, CO 80210  
Elected 09/19/94

Godela M Brosnahan, MD  
4605 S Yosemite St # 5  
Denver, CO 80237  
Elected 09/19/94



Camelia N Bui, MD  
1121 Albion St # 207  
Denver, CO 80220  
Elected 09/19/94

Brian J Burke, MD  
960 S Dahlia St #C  
Denver, CO 80222  
Elected 09/19/94

Marc Darrow, MD  
1001 E Bayaud Ave  
Denver, CO 80209  
Elected 09/19/94

Cherry Rose M DelosReyes, MD  
782 S Holly St  
Denver, CO 80222  
Elected 09/19/94

Tracy B Dill, MD  
4112 Waynesboro Ct  
Fort Collins, CO 80525  
Elected 09/19/94

Edward J Dunstan, DO  
770 S Routt Way  
Lakewood, CO 80226  
Elected 09/19/94

Andy M Fine, MD  
9085 E Mississippi Ave #D-102  
Denver, CO 80231  
Elected 09/19/94

Tunde Ghincea, MD  
1211 Vine St  
Denver, CO 80206  
Elected 09/19/94

Kevin J Goodluck, MD  
561 S Pearl St  
Denver, CO 80209  
Elected 09/19/94

Mary Beth Grotz, DO  
1771 S Quebec Way  
V 202  
Denver, CO 80231  
Elected 09/19/94

Geoffrey M Gullo, MD  
99 Corona St # 505  
Denver, CO 80218  
Elected 09/19/94

Karen D Hill, DO  
2365 N Springwood Ct  
Lafayette, CO 80026  
Elected 09/19/94

Mark T Holley, MD  
11210 W Jewell Dr  
Lakewood, CO 80227  
Elected 09/19/94

Jennifer J James, MD  
5663 W 71st Pl  
Arvada, CO 80003  
Elected 09/19/94

Alfred B Johnson, MD  
17039 E Atlantic Pl  
Aurora, CO 80013  
Elected 06/21/94

Cindy A Konecne, DO  
12764 E Asbury Cir # 302  
Aurora, CO 80014  
Elected 09/19/94

Ilana B Kutinsky, DO  
195 Jackson St # 35  
Denver, CO 80206  
Elected 09/19/94

Mark D Landers, MD  
15503 E Wyoming Dr # H  
Aurora, CO 80017  
Elected 08/24/94

Meg A Lemon, MD  
6495 Happy Canyon Rd # 109  
Denver, CO 80237  
Elected 09/19/94

Joseph A Lovato, DO  
11644 Grant St  
Northglenn, CO 80233  
Elected 09/19/94

Marianne V Lyons, DO  
770 S Routt Way  
Lakewood, CO 80226  
Elected 09/19/94

Maurice I Lyons, DO  
770 S Routt Way  
Lakewood, CO 80226  
Elected 09/19/94

Lex Mahler, DO  
429 Wright St # 12-312  
Lakewood, CO 80228  
Elected 09/19/94

Robert J Matejka, DO  
1150 S Cherry St # 2-303  
Denver, CO 80222  
Elected 09/19/94

Lisa M McKinney, MD  
9888 E Vasser Dr #I-308  
Denver, CO 80231  
Elected 07/25/94

Thomas P Moore, MD  
100 E Main St #101  
Aspen, CO 81611  
Elected 06/21/94

Darrell T Nivens Jr, MD  
1347 Cook St  
Denver, CO 80206  
Elected 09/19/94

Jill E Pechacek, MD  
2545 E Nichols Cir  
Littleton, CO 80122  
Elected 09/19/94

Beatriz Pelaez-Linn, MD  
2575 S Syracuse Way # D 307  
Denver, CO 80231  
Elected 09/19/94

J Brent Penland, MD  
9085 E Mississippi Ave # D 102  
Denver, CO 80231  
Elected 09/19/94

Kyle R Randall, MD  
225 S Jasper Cir # 26-307  
Aurora, CO 80017  
Elected 09/19/94

Janet C Ruzich, DO  
1050 Washington St # 1  
Denver, CO 80203  
Elected 09/19/94

Pushpasree Sajja, MD  
5250 Cherry Creek Dr S  
Denver, CO 80222  
Elected 09/19/94

James D Scott, DO  
3862 Glenmeadow Dr  
Colorado Springs, CO 80906  
Elected 06/21/94

Mark A Siemer, DO  
18020 E Bellwood Dr  
Aurora, CO 80015  
Elected 09/19/94

Ronald Silvius, DO  
11100 E Dartmouth Ave # 270  
Aurora, CO 80014  
Elected 09/19/94

Rupinder Singh, MBBS  
1394 Grape St  
Denver, CO 80220  
Elected 09/19/94

Mike Smith, DO  
7515 E Warren Dr # 4-104  
Denver, CO 80231  
Elected 09/19/94

Robin L Smith, DO  
876 S Oneida  
J-212  
Denver, CO 80224  
Elected 09/19/94

Thomas H Soper, DO  
4008 Newton St  
Denver, CO 80211  
Elected 09/19/94

Lynne S Spicer, MD  
635 Bellaire St  
Denver, CO 80220  
Elected 08/24/94

John M Spine, DO  
15 W Cimarron  
Colorado Springs, CO 80903  
Elected 09/19/94

Brindha Suresh, MD  
112 S Joliet Cir # 208  
Aurora, CO 80012  
Elected 09/19/94

Guido R Toscano, MD  
295 Zang St # 2943  
Lakewood, CO 80028  
Elected 09/19/94

Ann E Trawick, DO  
266 W Delaware Cir  
Littleton, CO 80120  
Elected 09/19/94

Mark B Walker, MD  
1150 Inca St # 52  
Denver, CO 80204  
Elected 09/19/94

Dana Wilson, DO  
6523 E Laguna Cir  
Highlands Ranch, CO 80126  
Elected 09/19/94

Catherine P Winslow, MD  
502 S Washington St  
Denver, CO 80209  
Elected 07/25/94

Mark C Winslow, DO  
555 E 10th Ave  
Denver, CO 80203  
Elected 09/19/94

William J Wirostko, MD  
1053 S Zeno Way # 204  
Aurora, CO 80017  
Elected 09/19/94

Jan E Woods, MD  
1442 Hudson St  
Denver, CO 80220  
Elected 07/25/94

Jeffrey J Zatorski, MD  
9888 E Vassar Dr  
Denver, CO 80231  
Elected 09/19/94

#### **CURECANTI MEDICAL SOCIETY**

Craig S Hammes, MD  
1010 S Cascade Ste B  
Montrose, CO 81401  
Elected 04/15/94

Patrick E Henderson, DO  
816 S 5th Street Ste B  
Montrose, CO 81401  
Elected 04/15/94

E Michael McPeak, MD  
816 S 5th Street  
Montrose, CO 81401  
Elected 04/15/94

J Kimberley Meyers, MD  
214 E Denver Ave  
Gunnison, CO 81230  
Elected 08/19/94

Stephen R Steele, DO  
PO Box 1229  
Telluride, CO 81435  
Elected 01/31/94

#### **DELTA COUNTY MEDICAL SOCIETY**

Douglas B Huene, MD  
70 Stafford Ln # 101 B  
Delta, CO 81416  
Elected 09/13/94

Kevin L Pulsipher, DO  
110 A SE Frontier Ave  
Cedaredge, CO 81413  
Elected 09/13/94

#### **DENVER MEDICAL SOCIETY**

Richard B Allen, MD  
777 Bannock St  
Denver, CO 80204  
Elected 11/01/94

John D Armstrong II, MD  
4200 E 9th Ave # A-030  
Denver, CO 80262  
Elected 09/01/94

Ruediger F Bracht, MD  
4500 E 9th Ave # 460  
Denver, CO 80220  
Elected 07/01/94

Karen K Darricau, MD  
1601 E 19th Ave # 4500  
Denver, CO 80218  
Elected 08/01/94

James C Duke, MD  
777 Bannock St  
Denver, CO 80204  
Elected 11/01/94

Lori C Fewin, MD  
3005 E 16th Ave # 300  
Denver, CO 80206  
Elected 07/01/94

Matthew D Flaherty, MD  
777 Bannock St  
Denver, CO 80204  
Elected 11/01/94

Kim S Friedman, MD  
6918 N Howell St  
Arvada, CO 80004  
Elected 10/01/94

Robert M Fromcheck, MD  
3969 E Arapahoe Rd #209  
Littleton, CO 80121  
Elected 06/01/94

Gary R Gray, DO  
4545 E Ninth Ave # 370  
Denver, CO 80220  
Elected 11/01/94

Brian C Hager, DO  
10154 E Fair Cir  
Englewood, CO 80111  
Elected 08/01/94

Deborah L Halterman, MD  
4545 E 9th Ave Ste 670  
Denver, CO 80220  
Elected 07/01/94

Michael H Handler, MD  
1010 E 19th Ave # 605  
Denver, CO 80218  
Elected 10/01/94

Richard R Hankenson, MD  
13952 Denver West Pkwy # 315  
Golden, CO 80401  
Elected 08/01/94

Leslie J Havard, MBCLB  
221 S Garfield St #209  
Denver, CO 80209  
Elected 06/01/94

Karen A Heuer, MD  
11326 Quivas Way  
Denver, CO 80234  
Elected 11/01/94

Bridget D Humphries, MD  
9799 E Jewell Ave # 204  
Denver, CO 80231  
Elected 09/01/94

Marc I Kerman, MD  
1001 E Bayaud Ave # 1602  
Denver, CO 80209  
Elected 10/01/94

Alan S Klein, MD  
818 E 19th Ave  
Denver, CO 80218  
Elected 09/01/94

Charles E Koftan, MD  
3005 E 16th Ave #300  
Denver, CO 80206  
Elected 06/01/94

Mary C Kohn, MD  
4500 E 9th Ave # 570-S  
Denver, CO 80220  
Elected 11/01/94

Dennis M Kotelko, MD  
1719 E 19th Ave  
OB-GYN  
Denver, CO 80218  
Elected 10/01/94

Diane M Lanese, MD  
13900 E Harvard Ave # 200  
Aurora, CO 80014  
Elected 09/01/94

Joyce A Moore, MD  
4500 E 9th Ave # 730  
Denver, CO 80220  
Elected 07/01/94



William S Moore, MD  
1355 S Colorado Blvd  
Denver, CO 80222  
Elected 06/01/94

John T Morrison, MD  
1000 S Broadway  
Denver, CO 80217  
Elected 06/01/94

Mary L Moyer, MD  
560 S 44th St  
Boulder, CO 80303  
Elected 04/01/94

Jeff S Nabonsal, MD  
1001 E Bayaud # 1908  
Denver, CO 80209  
Elected 11/01/94

Gary L Niemann, MD  
7350 S Ivy Way  
Englewood, CO 80112  
Elected 06/01/94

Denise C Norton, MD  
4545 E 9th Ave Ste 460  
Denver, CO 80220  
Elected 07/01/94

Todd K Ogawa, MD  
1315 Elm St  
Denver, CO 80220  
Elected 10/01/94

Pierre T Onda, MD  
13900 E Harvard Ave # 200  
Aurora, CO 80014  
Elected 08/01/94

James M Packer, MD  
777 Bannock St  
Denver, CO 80204  
Elected 11/01/94

Raymond J Rademacher, MD  
2121 S Oneida St # 200  
Denver, CO 80224  
Elected 10/28/94

Kamasamudram Ravi lochan, MD  
2877 S Xanadu Way  
Aurora, CO 80014  
Elected 07/01/94

Teresa Sexauer, DO  
44 Cook St # 203  
Denver, CO 80206  
Elected 11/01/94

Jennifer S Smith, MD  
4545 E 9th Ave # 220  
Denver, CO 80220  
Elected 08/01/94

Steven L Smith, MD  
198 Union Blve # 104  
Lakewood, CO 80228  
Elected 08/01/94

Theodore H Stathos, MD  
1601 E 19th Ave  
Denver, CO 80218  
Elected 09/01/94

Leslie A Stewart, MD  
1400 Jackson St  
Denver, CO 80206  
Elected 08/01/94

Dianne M Storey, MD  
6311 E 14th Ave  
Denver, CO 80220  
Elected 09/01/94

Initha V Stuckey, MD  
3511 Gaylord St  
Denver, CO 80205  
Elected 10/01/94

Kathleen K Traylor, MD  
2 Mountain High Ct  
Littleton, CO 80127  
Elected 08/01/94

S Andrew Tucker, MD  
2121 S Oneida St # 200  
Denver, CO 80224  
Elected 11/01/94

Walter E Vest III, MD  
2078 Forest St  
Denver, CO 80207  
Elected 09/01/94

Jay Y Want, MD  
4545 E 9th Ave # 120  
Denver, CO 80220  
Elected 08/01/94

Donald G Ward, DO  
29345 Roan Dr  
Evergreen, CO 80439  
Elected 06/01/94

Ann T Watlington, MD  
3005 E 16th Ave # 300  
Denver, CO 80206  
Elected 09/01/94

Gareth R Weiner, MD  
9141 Grant St # 125  
Thornton, CO 80229  
Elected 11/01/94

Kenneth J Weiner, MD  
2005 Franklin St Ste 210  
Denver, CO 80205  
Elected 07/01/94

Steven M Weiss, MD  
9400 E Iliff Ave # 232  
Denver, CO 80231  
Elected 09/01/94

Eric S Yaeger, MD  
499 E Hampden Ave # 230  
Englewood, CO 80110  
Elected 07/01/94

## **EASTERN COLORADO MEDICAL SOCIETY**

Phillip F Jackson, MD  
1177 Rose Ave  
Burlington, CO 80807  
Elected 09/01/94

## **EL PASO COUNTY MEDICAL SOCIETY**

Gregory F Bland, MD  
801 N Cascade Ave # 32  
Colorado Springs, CO 80903  
Elected 09/14/94

Donald D Bode Jr, MD  
3155 N Union Blvd  
Colorado Springs, CO 80907  
Elected 09/14/94

Keith O Bodrero, DO  
15 W Cimarron  
Colorado Springs, CO 80903  
Elected 09/19/94

Earl B Byrne, MD  
372 Printers Pkwy  
Colorado Springs, CO 80910  
Elected 11/02/94

William R Fry, MD  
25 E Jackson St # 201  
Colorado Springs, CO 80907  
Elected 11/02/94

James M Glass, MD  
525 N Foote Ave # 309  
Colorado Springs, CO 80909  
Elected 09/14/94

Timothy A Jamison, MD  
1400 E Boulder St  
Colorado Springs, CO 80909  
Elected 09/14/94

Anita K Lane, MD  
1715 N Weber St # 360  
Colorado Springs, CO 80907  
Elected 09/14/94

John D Lewis, MD  
175 W Cheyenne Rd # 208  
Colorado Springs, CO 80906  
Elected 09/21/94

Gregory J Liebscher, MD  
2727 N Tejon St  
Colorado Springs, CO 80907  
Elected 09/14/94

Stephen G MacIsaac, MD  
Dept of Urology  
Evans Army Hospital  
Fort Carson, CO 80913  
Elected 10/19/94

John P Ogrodnick, MD  
825 E Pikes Peak Ave  
Colorado Springs, CO 80903  
Elected 11/02/94

Ricky S Pionkowski, MD  
2131 N Tejon St # L-3  
Colorado Springs, CO 80907  
Elected 09/14/94

George E Schwender, MD  
825 E Pikes Peak Ave  
Colorado Springs, CO 80903  
Elected 11/02/94

Linda M Silveira, MD  
730 W Cheyenne Blvd #100  
Colorado Springs, CO 80906  
Elected 06/10/94

Anthony A Stanulonis, MD  
1432 Wood Ave  
Colorado Springs, CO 80907  
Elected 09/07/94

James J Steigerwald, MD  
4020 Palmer Park Blvd # 101 C  
Colorado Springs, CO 80909  
Elected 09/14/94

Jerry M Tarver, MD  
311 N Union Blvd  
Colorado Springs, CO 80909  
Elected 09/14/94

James B Towry, DO  
15 W Cimarron  
Colorado Springs, CO 80903  
Elected 09/19/94

Terry S Wade, DO  
3155 Woodland Hills Dr  
Colorado Springs, CO 80918  
Elected 06/21/94

William H Woodworth Jr, DO  
709 Main Street  
Security, CO 80911  
Elected 07/19/94

Dennis V Worthington, MD  
6455 N Union Blvd # 104  
Colorado Springs, CO 80918  
Elected 09/14/94

## **INTERMOUNTAIN MEDICAL SOCIETY**

Lawrence W Gaul, MD  
181 W Meadow # 500  
Vail, CO 81657  
Elected 11/01/94

Jean S Hadley, MD  
PO Box 1142  
Avon, CO 81620  
Elected 09/15/94

## **LARIMER COUNTY MEDICAL SOCIETY**

Caitlin M Ahern, MD  
1025 Pennock Pl  
Fort Collins, CO 80524  
Elected 12/31/93

Susan M Beck, MD  
1025 Pennock Pl  
Fort Collins, CO 80524  
Elected 12/31/93

Kevin M Beshlian, MD  
1701 E Prospect Rd  
Fort Collins, CO 80525  
Elected 06/20/94

Annette A Brower, MD  
2701 Madison Square Dr  
Loveland, CO 80538  
Elected 09/07/94

Christopher A Carpenter, MD  
1025 Pennock Pl  
Fort Collins, CO 80524  
Elected 09/07/94

David K Cobb, MD  
1247 Riverside Ste 1  
Fort Collins, CO 80524  
Elected 01/19/94

Chris Cribari, MD  
1247 Riverside Ave # 2  
Fort Collins, CO 80524  
Elected 12/01/93

Rebecca A delaTorre, MD  
914 W 6th St  
Loveland, CO 80537  
Elected 12/01/93

Sarah H Doerschuk, MD  
2500 E Prospect Rd  
Fort Collins, CO 80525  
Elected 09/07/94

David R Ferguson, MD  
1025 Pennock Pl  
Fort Collins, CO 80524  
Elected 01/19/94

Jacqueline C Fields, MD  
1025 Pennock Pl  
Fort Collins, CO 80524  
Elected 12/31/93

Kristine E Flowers, MD  
1025 Pennock Pl  
Fort Collins, CO 80524  
Elected 09/07/94

Jose R Hinojosa II, MD  
1025 Pennock Pl  
Fort Collins, CO 80524  
Elected 09/07/94

Rod R Holland, MD  
1212 E Elizabeth  
Fort Collins, CO 80524  
Elected 09/07/94

Daniel F Kaminsky, MD  
2439 Compass Ct  
Fort Collins, CO 80526  
Elected 09/07/94

Jeffrey N Kauffman, MD  
1217 E Elizabeth Ste 10  
Fort Collins, CO 80524  
Elected 12/01/93

Dana M Kettenring, MD  
424 S Impala Dr  
Fort Collins, CO 80521  
Elected 12/31/93

Bruce W Kornfeld, MD  
1355 Riverside Ave Ste # 2  
Fort Collins, CO 80524  
Elected 09/07/94

Susan H Kozak, MD  
1106 E Prospect Rd  
Fort Collins, CO 80525  
Elected 01/19/94

John G Martinez, MD  
1217 Riverside Dr  
Fort Collins, CO 80524  
Elected 09/07/94

Tamara A Miller, MD  
1033 Robertson St  
Fort Collins, CO 80524  
Elected 12/01/93

William E Miller, MD  
1100 E Elizabeth  
Fort Collins, CO 80524  
Elected 09/07/94

Garth C Nelson, MD  
1136 E Stuart # 3100  
Fort Collins, CO 80525  
Elected 09/07/94

Christopher J O'Grady, MD  
1025 Pennock Pl  
Fort Collins, CO 80524  
Elected 09/07/94

Lambert C Orton, MD  
1450 Dandie Way  
Estes Park, CO 80517  
Elected 09/07/94

David R Ottolenghi, MD  
3000 S College Ave # 210  
Fort Collins, CO 80525  
Elected 06/22/94

Jennifer M Phillips, MD  
1025 Pennock Pl  
Ft Collins, CO 80524  
Elected 09/07/94



John C Piccaro, MD  
1025 Pennock Pl  
Fort Collins, CO 80524  
Elected 12/31/93

Michael R Prochoda, MD  
838 Charter Oak Ct  
Loveland, CO 80538  
Elected 09/07/94

Jennifer S Tseng, MD  
1190 W Ash St  
Windsor, CO 80550  
Elected 06/22/94

John E Tweten, MD  
1025 Pennock Pl  
Fort Collins, CO 80524  
Elected 09/07/94

Deborah A Weiskittel, MD  
1113 Oakridge Dr  
Fort Collins, CO 80525  
Elected 01/19/94

Jeffrey R Weissmann, MD  
1632 Hoffman Dr # 2  
Loveland, CO 80538  
Elected 06/22/94

Barbara Widom, MD  
1808 Boise Ave  
Loveland, CO 80538  
Elected 12/01/93

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Elected 03/01/94

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Collbran, CO 81624  
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Erika E Woodyard, MD  
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RR #1 Box 6  
Collbran, CO 81624  
Elected 10/04/94

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Elected 07/15/94

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Pueblo, CO 81001  
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Pueblo, CO 81001  
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Elected 07/15/94

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4310 Wilderness Trail  
Pueblo, CO 81008  
Elected 08/04/94

Bryson R McHardy, MD  
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Pueblo, CO 81004  
Elected 07/19/94

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Pueblo, CO 81004  
Elected 10/13/94

Richard N Nanes, DO  
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Elected 10/02/94

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Pueblo, CO 81003  
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Elected 09/19/94

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Mark D Pinkerton, MD  
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Elected 09/19/94

Gladys A Richardson, MD  
PO Box 188  
Monte Vista, CO 81144  
Elected 06/01/94

Jeffrey C Troutt, DO  
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Alamosa, CO 81101  
Elected 06/01/94

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Alamosa, CO 81101  
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Greeley, CO 80631  
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Greeley, CO 80631  
Elected 04/02/94

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7 Dos Rios  
Greeley, CO 80634  
Elected 04/15/94

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2020 16th St  
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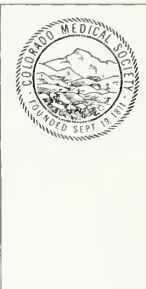
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## RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

The last time I talked to him he was still working on the history of the Department of Surgery at the School of Medicine.

J. Cuthbert "Cuth" Owens was always a delight to talk with, if you could steer clear of his wrath; he remained colorful and dramatic in speech, enthusiastic in spirit and as stubborn in personality as the day he came to Colorado. For the longest time he stubbornly refused to give in to an illness that would have cut most men down years before. "Cuth" Owens continued as a Delegate from the Denver Medical Society to the CMS House through March of '94, so I got to see him on a fairly regular basis, although I talked to him frequently when he would call and send me off to the archives to look up some aspect of CMS member history.

It seemed strange that he should be pursuing historic fact when Dr. Owens, himself, was a major historic factor in Colorado. He was a widely recognized authority on emergency services. He was one of the principals in the development of the mobile emergency medical facilities and the growth of paramedics. As far back as 1969 that hospitals were blamed for the time lag between an accident and the initiation of treatment. He said that essential to good emergency service are prompt, direct communications between the scene of the accident and the doctor and hospital. He said that doctors, by two-way radio and electronic scanners, can examine an accident victim and give treatment instructions to the scene of the accident and en route to the hospital.

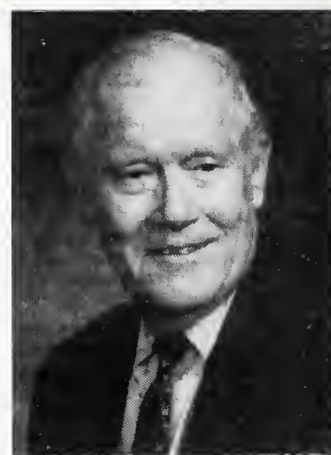
His visions came true. In the early 1970s, the first paramedic, life-support mobile systems appeared, capable of two-way communication, EKG, and very soon after, full transmission of vital signs to the emergency room physician. Today, these life-support ambulances are fully-equipped mobile emergency rooms.

Each of those advances in emergency treatment bears the mark of J. Cuthbert Owens, M.D.

In 1973, Dean Harry Ward appointed Dr. Owens Director of Emergency Services. In 1979, Dr. Owens was recognized for the development of a two-day continuing education course in emergency care for physicians in small Colorado and Wyoming communities. Eighty percent of the physicians in rural areas of the two states participated. The principal factor was that Dr. Owens developed a program which could be taken to the communities, and there was no tuition fee.

Here, then, is an idea which needs reinvention today. Things haven't changed: In 1979, Dr. Owens said "the lack of effective continuing education in rural areas is due more to the failure of educational institutions to implement programs than to lack of interest by the physicians themselves". He went on to say, "The rural physician's desire for continuing education is far greater than his opportunity to attend meetings."

Dr. Owens came to the University of Colorado in 1952 and is credited with developing the first full-time surgical faculty. He was appointed professor of surgery in



Denver Post Photo

James Cuthbert Owens, MD

1965. In 1986 he was named professor-emeritus and then began his archival quest to write the full history of the Department of Surgery.

The University of Colorado School of Medicine, Colorado medical practice and all of Colorado owes a lot to "Cuth" Owens. He will also be sorely missed.

The other day I went back to the archives for Dr. Owens. . . this time to close the file.











